Arizona Health Care
Cost Containment System (AHCCCS)

AHCCCS

2006–2007 External Quality Review Annual Report *for* ALTCS EPD and DES/DDD Contractors

June 2008

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997 (BBA) added Section 1932 to the Social Security Act (the Act), which pertains to Medicaid managed care. Section 1932(c) of the Act requires state Medicaid agencies to provide for an annual external independent review of the quality and timeliness of, and access to, services covered under each managed care organization (MCO) and prepaid inpatient health plan (PIHP) contract. The Code of Federal Regulations (CFR) outlines BBA requirements related to external quality review (EQR) activities.

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, §438.358(b) and (c). The three mandatory activities are: (1) validating performance improvement projects (PIPs), (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g). According to 42 CFR 438.358(a), "The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities."

AHCCCS was the first statewide Medicaid managed care system in the nation. It is recognized as a leader in designing and administering effective service delivery models for Medicaid managed care programs. Based on its extensive experience and expertise in managing and overseeing its Medicaid managed care programs, AHCCCS elected to conduct the mandatory activities. The agency developed and has consistently followed valid, tested models and processes to:

- Prepare for conducting each of the activities.
- Determine MCO and PIHP (i.e., "Contractor" within the AHCCCS system) compliance with financial and operational performance standards.
- Collect Contractor encounter and other data and use the data to directly calculate and measure Contractor performance for the AHCCCS-selected performance measures and required PIPs.
- Conduct overall validation of encounter data according to industry standards.

To meet the requirement of 42 CFR §438.358(b), an external quality review organization (EQRO) must use information from the three mandatory activities for each MCO and PIHP to prepare an annual technical report that includes the EQRO's:

- Analysis of the information.
- Conclusions drawn from the analysis of the quality and timeliness of, and access to, Medicaid managed care services provided to members by the State's MCOs and PIHPs.
- Recommendations for improving service quality, timeliness, and access.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG), to analyze the information AHCCCS obtained from conducting the mandatory activities and to prepare this 2006–2007 annual report. This is the fourth year that HSAG has prepared the annual report for AHCCCS. The report complies with requirements set forth at 42 CFR 438.364.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory activities and in using the information that either HSAG derived from directly conducting the activities or the state derived from conducting the activities. HSAG uses the information and data to draw conclusions and make recommendations about the quality and timelines of, and access to, care and services the State's MCOs and PIHPs provide.

This Executive Summary section includes an overview of HSAG's 2006–2007 external quality review and a high-level summary of the results. The results include a description of HSAG's findings with respect to AHCCCS Contractor performance in complying with federal and State standards, improving performance on AHCCCS-selected measures, and conducting valid and effective AHCCCS-required PIPs. A summary of HSAG's overall findings, conclusions, and recommendations across the three performance areas is also included in this section.

Additional sections of this 2006–2007 annual report include the following:

- Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS's quality assessment and performance improvement (QAPI) strategy goals and objectives
- Section 3—A description of the 2006–2007 EQRO activities that HSAG conducted
- Section 4—An overview of AHCCCS's statewide quality initiatives across its Medicaid managed care programs and those that are specific to the Arizona Long Term Care System (ALTCS) program (i.e., Elderly and Physically Disabled [EPD] Contractors and the Department of Economic Security/Division of Developmental Disabilities [DES/DDD] Contractor.
- Section 5—An overview of the Contractors' best and emerging practices
- Section 6 (Organizational Assessment and Structure Performance), Section 7 (Performance Measure Performance), and Section 8 (Performance Improvement Project Performance)—A detailed description of each of the three mandatory activities that includes for each activity:
  - AHCCCS's objectives for conducting the required activity and HSAG's objectives for aggregating and analyzing the data and preparing this report of findings and recommendations.
  - AHCCCS's methodologies for conducting the activity and HSAG's methodologies for using the AHCCCS data to prepare this annual report, including the technical methods of data collection and analysis, description of the data obtained, and how conclusions were drawn from the data.
  - Contractor-specific results and statewide comparative results across Contractors, including an assessment of Contractor strengths and opportunities for improvement.
  - HSAG's recommendations for improving the quality and timeliness of, and access to, care and services Contractors provide to members.

Overview of the 2006–2007 External Review

During contract year (CY) 2006–2007, AHCCCS contracted with nine Contractors to provide services to members enrolled in the ALTCS Medicaid managed care program. The nine Contractors were: Bridgeway Health Solutions, Cochise Health Systems, Evercare Select, Mercy Care Plan, Pima Health System, Pinal/Gila Long Term Care, SCAN Long Term Care, Yavapai County Long

Term Care, and the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD).

As described previously, AHCCCS directly performed the following functions related to the three mandatory activities for CY 2006–2007 for the ALTCS Elderly and Physically Disabled (EPD) Contractors and for DES/DDD:

- Conducted an extensive operational and financial review (OFR) of Contractor performance in meeting standards established by AHCCCS to comply with federal and State regulations, rules, and contract requirements. AHCCCS categorized and organized associated standards within 11 performance areas.
- Collected Contractor encounter and other data and used the data to directly calculate, analyze, and report Contractor performance for the AHCCCS-selected performance measures.
- Collected Contractor encounter and other data and used the data to directly calculate, measure, and report Contractor performance for the AHCCCS-required PIPs.
- Conducted overall validation of Contractor encounter data according to industry standards.
- Compiled and provided to HSAG: (1) A comprehensive and detailed written description of the processes and methodologies it followed in conducting the three mandatory activities related to Contractor compliance with standards, performance measures, and PIPs and (2) Contractor-specific performance results AHCCCS obtained from conducting each of the activities.

On January 16, 2008, HSAG and AHCCCS met to discuss and clarify AHCCCS's expectations for the annual external quality review report of findings for the three mandatory activities that AHCCCS performed. AHCCCS provided to HSAG detailed written information about the processes AHCCCS followed in conducting the activities and the Contractors' performance results for each. HSAG reviewed AHCCCS's documentation and developed a summary tool to crosswalk the data related to the Contractors' performance for each of the activities. Following a preliminary review of the documentation, and to ensure that HSAG was using complete and accurate information in preparing this annual report, HSAG developed and provided to AHCCCS a list of questions or requests for clarification related to AHCCCS's documentation and data. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the data and information.

HSAG provided monthly written status reports to AHCCCS that described HSAG's progress in completing each of the major work plan activities critical to preparing the annual report. HSAG provided a first draft of this annual report to AHCCCS for its review and comment on April 21, 2008.

Findings, Conclusions, and Recommendations About Timeliness, Access, and Quality of Care

The following section provides a high-level summary of HSAG's findings and conclusions about the quality and timeliness of, and access to, the care provided to AHCCCS members based on its analysis of the results AHCCCS obtained from:

- Conducting reviews of Contractor performance in complying with contractual requirements.
- Collecting data and calculating Contractor rates for AHCCCS-specified measures.
- Collecting data and calculating Contractor performance results from conducting AHCCCS-required PIPs.

Each section presents the overall outcomes of the activity across the ALTCS EPD and DES/DDD Contractors.

Organizational Assessment and Structure Standards

AHCCCS conducted an organizational assessment and structure review of Contractors' performance for eight ALTCS EPD Contractors and for the DES/DDD Contractor. AHCCCS reviewed the ALTCS EPD Contractors' performance on 110 to 123 compliance standards, depending upon the Contractor.[1-1] AHCCCS reviewed DES/DDD's performance on 122 standards.

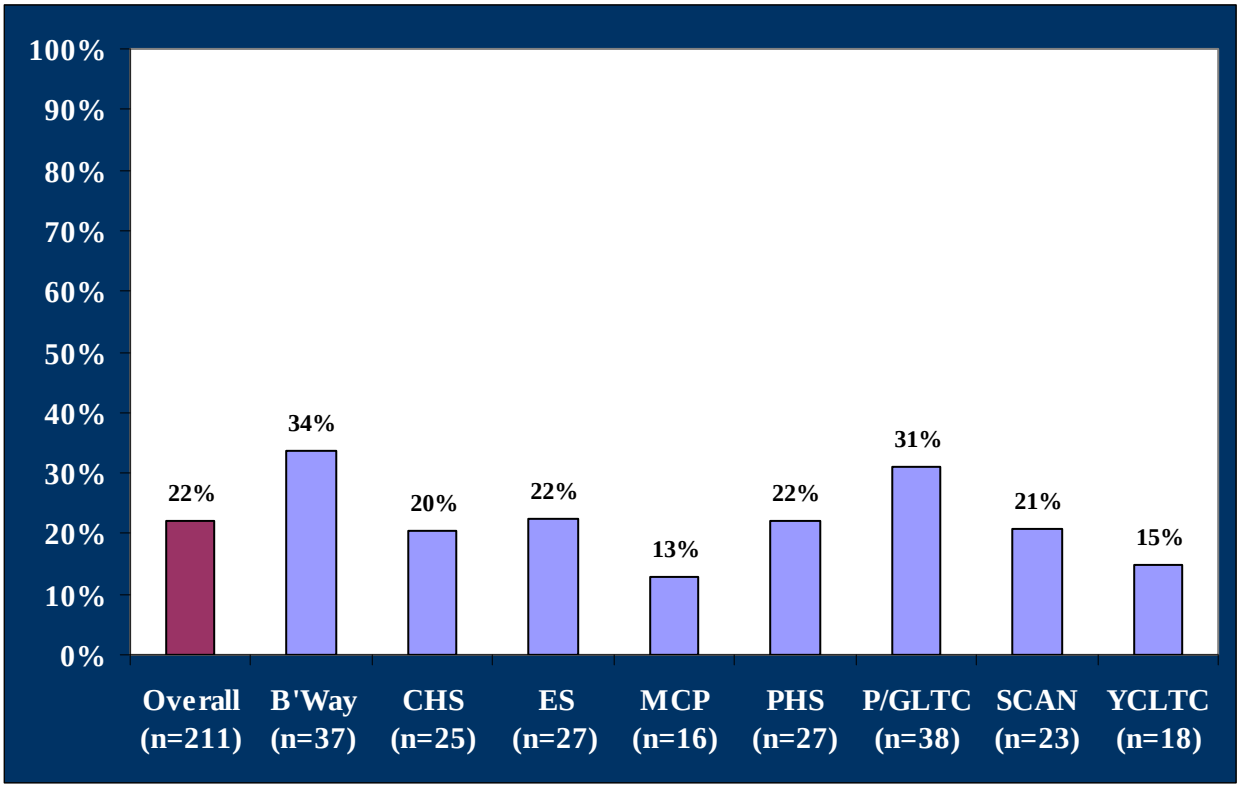
Findings

Based on AHCCCS's review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable performance designation to the Contractor's performance. *Full Compliance* was 90 to 100 percent compliant, *Substantial Compliance* was 75 to 89 percent compliant, *Partial Compliance* was 50 to 74 percent compliant, and *Non-Compliance* was 0 to 49 percent compliant. If a standard was not applicable to a Contractor, AHCCCS noted this using an *N/A* designation. When AHCCCS evaluates performance for a standard as less than fully compliant, it requires the Contractor to develop a corrective action plan (CAP), submit it to AHCCCS for review and approval, and implement the corrective actions. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced.[1-2] This situation occurred five times among the eight ALTCS EPD Contractors. With different numbers of required standards across ALTCS EPD Contractors and the presence of CAPs required for some standards in full compliance, the most valid method for comparing results is through the percentage of reviewed standards that required a CAP. The overall proportion of standards across all ALTCS EPD Contractors with a required CAP and the proportion for each Contractor are shown in Figure 1-1.

[1-1] Differences in the number of standards reviewed were due to some standards being not applicable to specific Contractors. For example, this year's review did not assess compliance with the Encounter standards for Bridgeway Health Solutions and SCAN Long Term Care, two new Contractors.

[1-2] Full compliance is noted when 90 to 100 percent of all required aspects of a standard are in compliance. As such, any portion of the standard not in compliance could still require a CAP.

Figure 1-1—Percentages of Compliance Standards With Required CAPs *for* ALTCS EPD Contractors[1-3]



On average, 22 percent of the reviewed compliance standards across all Contractors required a CAP. The percentage of standards requiring a CAP ranged from 13 percent (Mercy Care Plan) to 34 percent (Bridgeway Health Solutions). Overall, systemwide opportunities for improvement were noted since more than one in every five reviewed compliance standards required a CAP.

A comparison of the CAPs across compliance standards categories highlights general areas for quality improvement across the ALTCS EPD Contractors. Table 1-1 presents the total number of CAPs for each category of compliance standards across all Contractors. The table also shows the percentage of each category's reviewed standards that required a CAP, the total number of standards for each category, and the percentage of each category's standards that required a CAP.

[1-3] The Contractor names are abbreviated as follows: B'way=Bridgeway Health Solutions, CHS=Cochise Health Systems, ES=Evercare Select, MCP=Mercy Care Plan, PHS=Pima Health System, P/GLTC=Pinal/Gila Long Term Care, SCAN=SCAN Long Term Care, YCLTC=Yavapai County Long Term Care.

Table 1-1—Corrective Action Plans by Category for All ALTCS EPD Contractors				
Category	CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	20	9%	160	13%
Delivery Systems	12	6%	88	14%
Authorization & Denial/Grievance Systems	51	24%	151	34%
Case Management	7	3%	32	22%
Behavioral Health	17	8%	64	27%
Medical Management	34	16%	80	43%
Quality Management	25	12%	85	29%
Maternal/Child Health	4	2%	24	17%
Financial Management	15	7%	98	15%
Claims System	16	8%	104	15%
Encounters	10	5%	66	15%
Overall	**211**	**100%**	**952**	**22%**

Table 1-1 shows that the category with the fewest CAPs was Maternal/Child Health, with only four CAPs required across all Contractors. The most CAPs were required for the Authorization and Denial/Grievance Systems category (51 CAPs). Proportional to the number of standards within each category, the General Administration category exhibited the highest performance with only 13 percent of its standards requiring a CAP. Conversely, 43 percent of the standards in the Medical Management category required a CAP. This represents more than two out of every five standards reviewed. This finding strongly suggests a statewide opportunity for improvement in this operational area. Additionally, more than one-third (34 percent) of the standards in the Authorization and Denial/Grievance Systems category required a CAP followed by Case Management (22 percent), Behavioral Health (27 percent), and Quality Management (29 percent).

Overall, 53 percent of DES/DDD's reviewed standards required a CAP in CYE 2007 (see Table 6-9, page 6-45). The greatest percentage of required CAPs per category was for the Maternal/Child Health category, where 90 percent (9 out of 10) of the reviewed standards required a CAP. The Quality Management category also had a low percentage of standards in full compliance as evidenced by 8 of the 10 standards requiring a CAP (80 percent). In general, all of the categories of standards for DES/DDD had multiple required CAPs except General Administration, which required only one CAP (5 percent). However, improvement from the previous review was exhibited in the overall proportion of CAPs required for DES/DDD. For the categories that could be compared[1-4] between the two review cycles, DES/DDD saw a change of 11 percentage points, from 63 percent (CYE 2006) to 52 percent (CYE 2007), in the proportion of reviewed standards that required a CAP. This reduction represents a 17 percent improvement in DES/DDD's performance for the standards.

[1-4] Several categories of standards were not reviewed in both CYE 2006 and CYE 2007. In CYE 2007, the Utilization Management category was no longer evaluated and the Financial Management, Claims Systems, and Encounters categories were added.

Conclusions

Except for DES/DDD, AHCCCS's ALTCS Contractors' performance cannot be compared to their 2006 performance because a comparable, extensive review was not conducted in CYE 2006. For the 2006 review, AHCCCS only reviewed the sufficiency of the Contractor's CAPs submitted in response to AHCCCS's 2005 extensive review. Nonetheless, the relatively large proportion of standards requiring a CAP suggests significant opportunities for improvement across the ALTCS EPD Contractors regarding the performance standards. While DES/DDD made some improvements since the previous review period, more than half of the reviewed standards in CYE 2007 required a CAP. This finding represents a considerable opportunity for improvement.

Recommendations

For the highest-performing Contractor with the greatest proportional compliance with the performance standards, approximately one in every seven compliance standards required a CAP. The proportion increased to more than one in every three compliance standards requiring a CAP for the lowest-performing Contractor. The range of results supports the recommendation for systemwide operational improvements across the Contractors. Improvement activities should focus on more effectively using existing quality and medical management committees focused on enhancing monitoring and oversight of Contractor performance, and implementing targeted improvement activities and interventions.

The reviewed standards within the Medical Management category show the greatest statewide opportunity for improvement with 43 percent of the reviewed standards requiring a CAP. This percentage is substantively higher than the percentage of CAPs required for any other category. Additionally, seven of the eight ALTCS EPD Contractors had a required CAP for the Medical Management standard ("The Contractor has implemented and monitors a comprehensive inter-rater reliability plan to ensure consistent application of criteria for clinical decision making"). Except for Mercy Care Plan, which was fully compliant, this standard is a statewide opportunity for improvement for the ALTCS EPD Contractors.

DES/DDD should continue its aggressive efforts to reduce the number of required CAPs. Since many of the CAPs involve administrative procedures and monitoring/feedback processes, DES/DDD should consider evaluating its current operational systems and committee structures to enhance the monitoring and oversight of current performance. Further, in some cases, these procedures and processes may need to be resolved by designating responsibility and accountability for improving performance and resolving existing CAPs within each performance category to a staff member and/or committee.

Performance Measures

AHCCCS collected Contractor data and calculated Contractor performance rates for AHCCCS-selected measures in both the previous and current reporting periods. As a result, the findings, conclusions, and recommendations are based on performance results for the current review and the change in performance over the two most recent reporting periods.

Findings

Table 1-2 presents the mean performance measure rates across the six ALTCS EPD Contractors. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2007 minimum performance standards (MPS), goals, and long-range benchmarks.

Table 1-2—Performance Measurement Review *for* ALTCS EPD Contractors

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[B]	89.1%	92.5%	3.8%	p=.069	84%	85%	98%
HbA1c Testing	74.8%	**79.7%**	**6.6%**	**p=.007**	75%	77%	88%
Lipid Screening	73.6%	**80.9%**	**9.9%**	**p<.001**	76%	78%	85%
Retinal Exams	66.6%	**60.4%**	**-9.4%**	**p=.003**	45%	47%	64%
EPSDT Participation	56.5%	59.8%	5.8%	p=.413	50%	53%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between the performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] HCBS = Home and Community-Based Services. If Contractors are achieving the MPS, they should strive for 85 percent or higher.

Using the CYE 2007 MPS, goals, and long-range benchmarks as frames of reference, the ALTCS EPD Contractors are performing well, overall. In general, the average performance measure rates across those ALTCS EPD Contractors[1-5] with reported data exhibited rates above the CYE 2007 AHCCCS goals. However, while the ALTCS EPD Contractor rate for Retinal Exams previously exceeded the AHCCCS long-range benchmark, it declined below this benchmark in CYE 2007. The statistically significant decline in this rate represents an important statewide opportunity for improvement.

From a quality improvement perspective, the performance measure results illustrated overall improvement when compared with the previous year's result. Of the five measures, two showed statistically significant gains (HbA1c Testing and Lipid Screening), one showed results suggesting a gain (Initiation of Home and Community-Based Services), one was statistically unchanged (EPSDT [Early and Periodic Screening, Diagnosis and Treatment program] Participation), and one of the measures demonstrated a statistically significant decline (Retinal Exams). However, caution should be used when evaluating this decrease since data collection processes were modified in the current measurement period to better conform to HEDIS methodology. These changes may have affected the reported retinal exam rates. The mean Contractor rate for the performance measures increased for three of the six ALTCS EPD Contractors and decreased for the remaining three Contractors (see Figure 7-1, page 7-24).

[1-5] Two Contractors, Bridgeway Health Solutions and SCAN Long Term Care, were new EPD Contractors for CYE 2007 and were not required to submit reportable data for this year's performance measures.

Table 1-3 presents the ALTCS EPD Contractors' required CAPs for the previous and the current review cycles. The table shows each of the performance measures, the previous number of CAPs required, the CYE 2006 MPS, the current number of CAPs required, and the CYE 2007 MPS. Although separately shown, the MPS remained constant between CYE 2006 and CYE 2007.

Table 1-3—Performance Measures—Corrective Action Plans Required *for* ALTCS EPD Contractors

Performance Measure	CYE 2006		CYE 2007	
	Number of CAPs (10/1/04–9/30/05)	AHCCCS Minimum Performance Standard	Number of CAPs (10/1/05–9/30/06)	AHCCCS Minimum Performance Standard
Initiation of HCBS[A]	0	84%	1	84%
Diabetes Management—HbA1c Testing	3	75%	1	75%
Diabetes Management—Lipid Screening	3	76%	0	76%
Diabetes Management—Retinal Exam	0	45%	0	45%
EPSDT Participation	2	50%	1	50%
Total Performance Measure CAPs	**8**		**3**	

[A] HCBS = Home and Community-Based Services.

The current review cycle saw a marked reduction in the number of required CAPs for the five performance measures across the ALTCS EPD Contractors, decreasing from eight CAPs in CYE 2006 to three CAPs in CYE 2007. This reduction represents a 63 percent improvement in the number of required CAPs, including the resolution of all three previously required CAPs for Lipid Screening, two of the three CAPs for HbA1c Testing, and one of the two CAPs for EPSDT Participation. In contrast, where the previous measurement cycle did not show any required CAPs for Initiation of HCBS, the current assessment shows one required CAP for one Contractor.

For DES/DDD, a review of its results for performance measures during the past two years suggested several key findings (see Table 7-7, page 7-20). First, rates across the performance measures presented mixed results, with some performance measures exceeding AHCCCS's MPS (Well-Child Visits—3, 4, 5, and 6 Years; Annual Dental Visit; and EPSDT Participation), and others remaining below required performance levels (Children's Access to PCPs and Adolescent Well-Child Visits). Overall, rates for six of the nine comparable measures dropped, with two of the rates (Children's Access to PCPs [total] and for children 12–24 months of age) declining significantly. However, programming changes for the Children's Access to PCPs measure implemented by AHCCCS in order to conform to current HEDIS requirements may have affected the results for these measures. Second, the number of required CAPs for comparable measures decreased from four in CYE 2006 to two during the current review. The noted decrease represents some level of improvement by DES/DDD.

Conclusions

The results suggest substantive improvements for four of the five rates for the EPD contractors and an opportunity to improve the fifth rate (Retinal Exams). However, reported decreases may not reflect a substantive change in rates since programming changes were implemented to better align

with HEDIS methodology. Overall, the ALTCS EPD Contractors have performed well by generally exceeding the AHCCCS CYE 2007 MPSs and goals. Additionally, while DES/DDD has improved on the overall number of CAPs required for the current review cycle, the rates for the performance measures present mixed results.

Recommendations

Although rates decreased in the current review period, Contractor performance for the Retinal Exams measure did not require CAPs in either CYE 2006 or CYE 2007 and greatly exceeded the MPS for both years. This finding suggests that performance for the measure is a strength for the ALTCS EPD Contractors. Nonetheless, the current decline suggests an opportunity to improve the overall rate by returning performance to the previous level. However, due to methodological changes, this decrease may not reflect a substantive change in rates. No other ALTCS EPD Contractor-wide opportunity for improvement is evident from the current performance measure review. However, the ALTCS EPD Contractors should continue to monitor performance across clinical and nonclinical measures to ensure rates remain at or above established minimum performance standards and goals.

For DES/DDD, Children's Access to PCPs and Adolescent Well-Child Visits represent two overarching areas with an opportunity for improvement. These measures address all three aspects of care outlined in the BBA regulations—i.e., access, timeliness, and quality. As such, efforts should be made to evaluate the impact of expanding the current provider network where needed, and to address access through extended hours and enhanced transportation options.

Performance Improvement Projects (PIPs)

AHCCCS provided to HSAG the results it obtained from collecting and calculating PIP remeasurement performance results for six ALTCS EPD Contractors[1-6] and the DES/DDD Contractor. The remeasurement data for all contractors was from October 1, 2004, to September 30, 2005.[1-7] The EPD Contractor-reported measures for the Management of Comorbid Diseases PIP included: median number of inpatient days, median number of outpatient encounters, and median number of emergency room/urgent care (ER/UC) visits. For DES/DDD, AHCCCS required the Immunization Completion Rates by 24 Months of Age PIP to be continued and reported in this CYE 2007 annual report because the Contractor had not yet met AHCCCS's requirements for a completed PIP.

Findings

The most compelling finding for the EPD Contractor PIPs was the overall increase in the Median Number of Outpatient Encounters. Figure 1-2 presents the results for this measure for the six ALTCS EPD Contractors.

[1-6] Two Contractors, Bridgeway Health Solutions and SCAN Long Term Care, were new ALTCS EPD Contractors for CYE 2007 and were not required to submit reportable data for this year's performance measures.
[1-7] This PIP is a longitudinal study in which data is compared over a three-year period. The initial baseline measurement period for this PIP was October 1, 2002, to September 30, 2003.

Figure 1-2—Two-Year Comparison of Median Number of Outpatient Encounters *for* All ALTCS EPD Contractors[1-8]

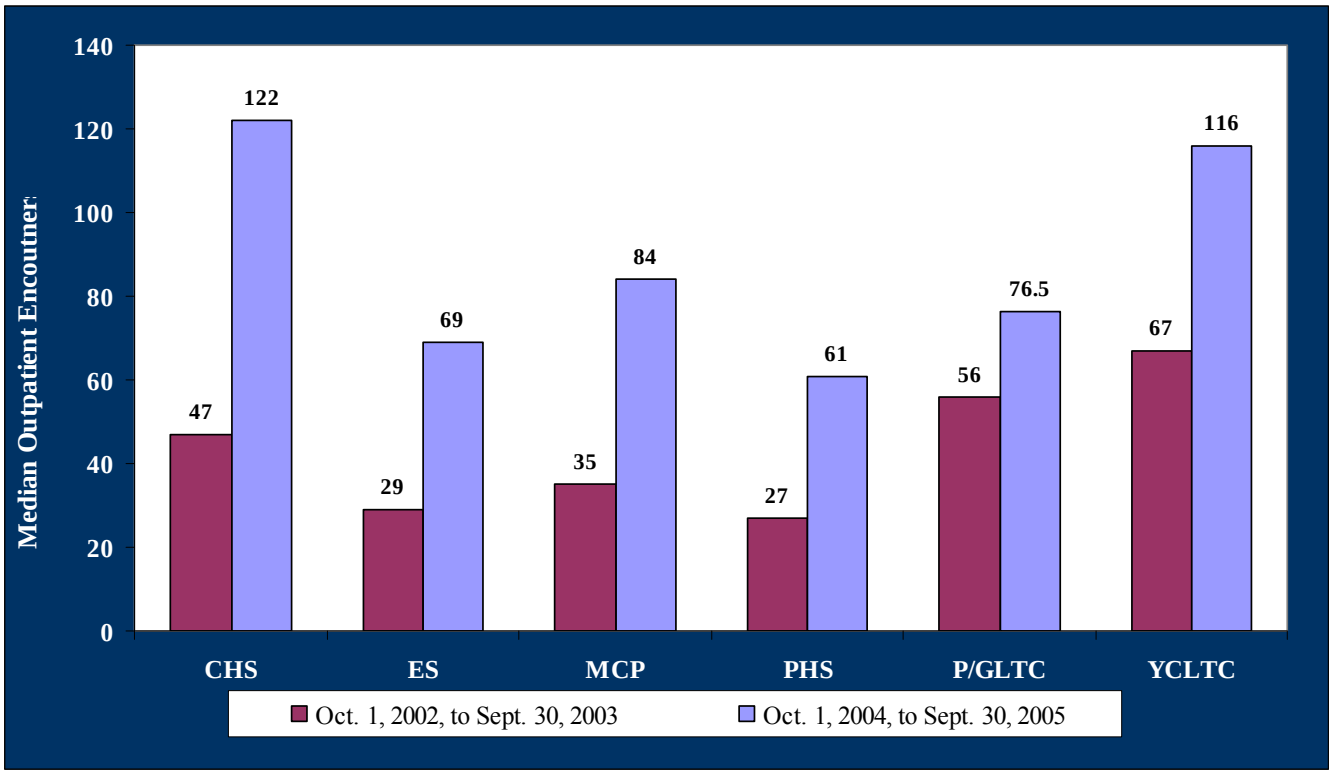


Figure 1-2 illustrates that the median number of outpatient encounters increased substantively for each of the ALTCS EPD Contractors. Moreover, the overall rate of outpatient encounters exhibited a statistically significant increase from baseline rates ($p<.001$). When stratified by ALTCS EPD Contractors, the results showed that only one Contractor's rate remained statistically unchanged from the baseline measurement period. This finding suggests improved coordination of care and access to preventive services for these members.

The values for median number of inpatient days and ER/UC encounters were generally zero or one. Overall, the only statistically significant change in the median number of inpatient days was for P/GLTC, which had its median decrease significantly from 2.5 to 0 days ($p=.006$). This result suggests successful execution of the PIP by P/GLTC. The results for the median number of ER/UC visits significantly increased for all EPD Contractors except P/GLTC.

In addition to the reported measures, the Management of Comorbid Diseases PIP included an evaluation of the extent to which members' outcomes worsened, remained the same, or became better over time. These outcomes were determined by changes in members' acuity status, placement, and mortality status. Overall, outcomes worsened for 29.8 percent of the sample frame (moving from Level I or II to a higher level). This average percentage ranged from 25.3 percent to 34.7 percent across individual Contractors. The outcomes became better for 4.8 percent of the

[1-8] The Contractor names are abbreviated as follows: CHS=Cochise Health Systems, ES=Evercare Select, MCP=Mercy Care Plan, PHS=Pima Health System, P/GLTC=Pinal/Gila Long Term Care, and YCLTC=Yavapai County Long Term Care.

participating members, while the majority of members (65.4 percent, or 259 of 396 members across all Contractors) had outcomes that remained the same between measurement periods. When interpreting these results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

The second remeasurement rate for the DES/DDD Immunization PIP (65.2 percent) increased by 20.0 percentage points from the first remeasurement period (45.2 percent), a substantively large amount. This improvement represented a relative increase of 44.2 percent and was statistically significant (p=.003). However, despite the noted improvement, DES/DDD's immunization rate still illustrates an opportunity for improvement.

Conclusions

The performance of the six ALTCS EPD Contractors returned mixed results for the Management of Comorbid Diseases PIP. Although the median number of outpatient encounters increased by a statistically significant and substantive amount, improvements in the median number of inpatient days and ER/UC visits were not found. Specifically, the median number of impatient days remained unchanged except for one Contractor, while the median number of ER/UC visits significantly increased. Both results suggest that additional efforts are needed to manage members with multiple comorbid diseases more effectively to prevent them from needing to access services through more intensive and costly ER/UC and inpatient settings.

Additionally, while DES/DDD showed marked improvement in the remeasurement of its immunization PIP, it continues to illustrate an opportunity for improvement. As such, current outreach efforts should continue to further improve gains illustrated in the second remeasurement.

Recommendations

Two of the three quality indicators for the current PIP have not yet shown clear evidence of EPD Contractor-wide improvement (i.e., median number of inpatient days and ER/UC visits). The factors contributing to these outstanding opportunities for improvement were not clear from the available documentation and may not be known to the Contractors. In concert with the expected quality improvement activities of a PIP, HSAG recommends that ALTCS EPD Contractors perform a root-cause analysis to identify why operationalized interventions have been unsuccessful or less effective than anticipated. Based on the results of this analysis, Contractors may need to strengthen current interventions and/or implement additional ones.

Based on the reported improvement in its PIP, DES/DDD has demonstrated that it is employing effective interventions. However, since DES/DDD had not yet fulfilled the requirements for completing a PIP, it is recommended that current efforts to improve the percentage of children receiving immunizations continue.

Overall Findings, Conclusions, and Recommendations

ALTCS EPD Contractors are making progress toward improving the delivery of services and quality of care provided to their members. This conclusion is evidenced by the results of the three activities AHCCCS conducted, for which HSAG analyzed and documented its findings and recommendations in this report. Using the results from the compliance review and from calculating Contractors' rates for AHCCCS-selected performance measures and PIPs to guide and facilitate improvement, AHCCCS has implemented a comprehensive system to monitor and improve the timeliness of, access to, and quality of care Contractors provide to Medicaid members.

In its review and analysis of performance measure results, AHCCCS found substantive improvements in the rates compared to the previous measurement period. Overall, four of the five performance measure rates showed increases, with two of the increases reaching statistical significance ($p \leq .05$). The fifth rate, for Diabetes Management—Retinal Exams, showed an opportunity for improvement since the rate significantly declined in CYE 2007 ($p=.003$). However, the Diabetes Management—Retinal Exam rate still remained above the AHCCCS goal. Additionally, as a group, ALTCS EPD Contractors exceeded both the AHCCCS MPSs and goals for every performance measure, although individual Contractor performance varied. These results suggest that AHCCCS's system of monitoring results and requiring CAPs has been effective for improving and achieving high-quality care for Medicaid members. All five of these measures can be considered to address quality, timeliness, and/or access to care and services. For example, the diabetes management indicators all assess quality (by following best practices guidelines), timeliness (by including a frequency criterion), and access (by members being able to make and keep appointments with various providers).

AHCCCS's requirement for the Management of Comorbid Diseases PIP was particularly effective for increasing the median number of outpatient encounters for eligible members. The increase in outpatient encounters for this high-risk population presents more opportunities for providers to control the progression of members' diseases. Additionally, in time, an increase in the median number of outpatient encounters should reduce the frequency of members' acute episodes. Evidence of this reduction has not yet been seen, but the substantively large increase in the median number of outpatient encounters has definitely been achieved.

Within the organizational assessment and structure standards, performance across ALTCS EPD Contractors suggests a generalized, statewide opportunity for improvement. Overall, 22 percent of all operational and financial standards required a CAP in CYE 2007. Because AHCCCS conducted a follow-up review of EPD Contractor CAPs in 2006 and not an extensive review comparable to its CYE 2007 review, a comparative assessment of performance between the two review cycles could not be completed for the ALTCS EPD Contractors. However, the effectiveness of AHCCCS's monitoring and CAP process can be seen through the proportional change in CAPs across the two most recent measurement cycles for DES/DDD, for which AHCCCS conducted comparable, extensive reviews for both CYE 2006 and CYE 2007. For overlapping categories of standards, the Contractor achieved a 17 percent relative reduction in the percentage of CAPs between the two most recent review cycles.

In general, and as documented in detail in other sections of this report, ALTCS EPD and DES/DDD Contractors made important improvements in the timeliness of, access to, and quality of care they

provide to Medicaid members. While several opportunities for improvement are highlighted throughout the report, the opportunities and the associated recommendations should not detract from the overall progress that has been made.

DES/DDD also made important progress as determined by the results of each of the three activities AHCCCS conducted. Although a significant number of opportunities for improvement still exist, DES/DDD proportionately reduced the number of required CAPs for the review of compliance standards and for its performance measure rates, and has made good progress with its PIP.

2. Background

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS's Quality Assessment and Performance Improvement (QAPI) Strategy. The description of the QAPI strategy summarizes AHCCCS's:

- Quality strategy goals and objectives.
- Operational performance standards used to evaluate Contractor performance in complying with BBA regulations and State contract requirements.
- Requirements and targets AHCCCS used to evaluate Contractor performance on AHCCCS-selected measures and to evaluate the validity of and improvements achieved through the Contractors' AHCCCS-required PIPs.

History of the AHCCCS Medicaid Managed Care Program

AHCCCS, the first statewide Medicaid managed care system in the nation, has operated under an 1115 Research and Demonstration Waiver since 1982, when it began its Acute Care Program. The Arizona Long Term Care System (ALTCS) program was added in December 1988 for individuals with developmental disabilities and then further expanded in January 1989 to include the EPD populations. Coverage of comprehensive behavioral health services began in October 1990 for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Under its last expansion, all Medicaid-eligible individuals now have comprehensive behavioral health coverage. AHCCCS has operated throughout its 25-year history as a pioneer and recognized, respected leader in developing and managing innovative, quality, and cost-effective Medicaid managed care programs.

AHCCCS contracts with private and public managed care organizations (MCOs) and two prepaid inpatient health plans (PIHPs) to provide services to its members statewide. The two PIHPs are each contracted to provide a defined and limited scope of services (i.e., one provides behavioral health services and the other provides children's rehabilitation services). Within the AHCCCS program, the MCOs and the PIHPs are called "Contractors."

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.200 and §438.202 implement Section 1932(c)(1) of the Act, defining certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) must meet. The Medicaid state agency must, in part:

- Conduct periodic reviews to examine the scope and content of its quality strategy and evaluate its effectiveness.
- Ensure compliance with standards established by the state that are consistent with the federal Medicaid managed care regulations.
- Update the strategy periodically as needed.
- Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

While AHCCCS has had a formal QAPI plan since 1994, it established and submitted its initial quality strategy to CMS in 2003. It has continued to update the strategy as needed and to submit revisions to CMS. AHCCCS's QAPI strategy was last revised and forwarded to CMS in December 2007.

AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS may also involve other internal and/or external collaborations/participants.

Quality Strategy Objectives

AHCCCS's mission is "Reaching across Arizona to provide comprehensive, quality health care to those in need." Consistent with this mission, AHCCCS states in its quality strategy that:

- AHCCCS develops the strategy through identifying specific goals and objectives.
- The quality strategy provides a framework for AHCCCS's overall goal of improving and/or maintaining the members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions.
- The overarching quality strategy objective is to design and implement "a coordinated, comprehensive, and pro-active approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance improvement ... designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of services."

The quality strategy objectives are one component of the agency's five-year strategic plan. AHCCCS's strategies for evidence-based outcomes and quality initiatives address its broad quality goals and objectives and include:

- Rewarding quality of care, member safety, and member satisfaction outcomes.
- Supporting best practices in disease management and preventive care.
- Providing feedback on quality and outcomes to Contractors and providers.
- Providing comparative information to consumers.

AHCCCS's QAPI strategy describes detailed goals and objectives that address, in part:

- Enhancing performance measure, performance improvement, and best practice activities as one approach to developing a statewide QAPI roadmap for driving improvement in member-centered outcomes.
- Building upon prevention efforts and health maintenance/management to improve members' health status through targeted medical management.
- Developing collaborative strategies and initiatives with State agencies and other partners to improve access, health outcomes, and health education; manage vulnerable and at-risk members; and build professional and paraprofessional capacity in underserved areas.
- Enhancing customer service.
- Improving information retrieval and reporting capacity.

Operational Performance Standards

The Assessment section of AHCCCS's QAPI strategy describes the processes AHCCCS uses to assess the quality and appropriateness of care/services for members with routine and special health care needs. The assessment processes include, but are not limited to, conducting annual OFRs of Contractors and reviewing their deliverables required by contract, program-specific performance measures, and performance improvement projects. AHCCCS conducts OFRs and reviews Contractor deliverables to meet the requirements of Medicaid managed care regulations (42 CFR §438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with additional federal and State regulations as well as AHCCCS contract requirements and policies. As part of the OFRs, AHCCCS staff review Contractor progress in implementing recommendations made during prior OFRs and determines each Contractor's compliance with its own policies and procedures.

At least every three years, AHCCCS reviews Contractor performance in complying with standards in all 14 performance areas to ensure Contractor compliance with BBA requirements and AHCCCS contract standards. AHCCCS may review some areas more frequently—sometimes annually—if the requirements are new, there are Contractor compliance issues, or the requirements are in an area of special focus. AHCCCS issues a performance report to each Contractor that includes AHCCCS's findings and the Contractor's scores for each standard AHCCCS reviewed in each performance area. The scores define the degree to which the Contractor's performance is in compliance with the requirements, i.e., *Full Compliance* (90–100 percent), *Substantial Compliance* (75–89 percent), *Partial Compliance* (50–74 percent), *Non Compliance*, (0–49 percent). If a standard is not applicable for a Contractor, AHCCCS notes this using an *NA* designation. AHCCCS also documents its recommendations to improve Contractor performance. For AHCCCS recommendations stated as the Contractor "*must*" or the Contractor "*should*" ... AHCCCS requires Contractors to submit detailed CAPs to AHCCCS for its review and acceptance.

The performance areas AHCCCS evaluates are:

- Behavioral Health
- Case Management
- Claims Systems
- Corporate Compliance

- Cultural Competency
- Delegated Agreements
- Delivery System
- General Administration
- Grievance System
- Maternal and Child Health
- Medical Management
- Quality Management
- Reinsurance
- Third Party Liability

For the 2006–2007 OFR, AHCCCS initiated a new three-year cycle of OFRs and evaluated Contractor performance in 11 areas.

Examples of deliverables that Contractors are required to submit to AHCCCS for its review include, but are not limited to, the following:

- Annual Case Management Plan
- Annual Cultural Competency Evaluation
- Annual EPSDT Plan (including dental)
- Annual Medical Management Plan and Evaluation
- Annual Network Development and Management Plan
- Annual Quality Management Plan and Evaluation
- Quarterly EPSDT Progress Reports
- Quarterly Quality Management Reports

Performance Measure Requirements and Targets

AHCCCS's quality strategy describes the agency's processes to define, collect, and report Contractor performance data on AHCCCS-required measures. AHCCCS uses the Healthcare Effectiveness Data and Information Set (HEDIS®[2-1]) for most of its performance measures. Examples of measures for any given year could include adolescent well-care visits, childhood immunizations, and annual dental visits. AHCCCS annually establishes a minimum performance standard (MPS), goal, and long-range benchmark for each measure. Contractors not meeting the MPS for any given measure are required to submit to AHCCCS corrective action plans (CAPs) that include the Contractors' planned interventions that will assist them in meeting the MPS.

For the measurement year ending September 30, 2006, AHCCCS calculated and reported ALTCS EPD Contractors' performance rates for the following AHCCCS-required measures:

- Comprehensive Diabetes Care (i.e., HbA1c Testing, LDL-C Screening, and Eye Exam)

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Initiation of Home and Community Based Services
- EPSDT Participation

For DES/DDD, AHCCCS calculated and reported performance rates for the following AHCCCS-required measures:

- Children's Access to Primary Care Providers
- Well-Child Visits (Third, Fourth, Fifth, and Sixth Years if Life)
- Adolescent Well-Care Visits
- Annual Dental Visit (Ages 4–21)
- EPSDT Participation

Performance Improvement Project Requirements and Targets

AHCCCS's QAPI strategy described the agency's requirements and processes to ensure that Contractors conduct PIPs, which the QAPI defined as "a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome"—i.e., to improve the quality of care and service delivery. AHCCCS encourages its Contractors to conduct PIPs that they select (e.g., assessment of appropriate use of medications for members diagnosed with asthma and improving medically necessary transportation for long-term care members, which were under way when AHCCCS submitted to CMS its December 2007 QAPI strategy). However, AHCCCS also selects PIPs that the Contractors must conduct. The PIPs that the Acute Care and DES/CMDP Contractors must conduct during any given time period may or may not be the same as those that the ALTCS EPD and DES/DDD Contractors must submit. For example, AHCCCS required all Contractors to conduct a diabetes improvement PIP, which was completed in 2006 and resulted in improvements in preventative care and outcomes in the management of members diagnosed with diabetes. For 2007, the AHCCCS-required PIPs were not the same for all contractors.

For the AHCCCS-mandated PIPs, AHCCCS and the Contractors measure performance for at least two years after Contractor baseline rates and interventions are implemented to show not only improvement, but also sustained improvement, as required by the BBA. While AHCCCS does not establish minimum performance targets for Contractors, it does require Contractors to demonstrate improvement and then sustain the improvement over at least one subsequent remeasurement cycle. AHCCCS requires Contractors to submit reports evaluating their data and interventions, and proposing new or revised interventions, if necessary.

For the period covered by this report, AHCCCS required the ALTCS EPD Contractors to report their first remeasurement data for the second year of their PIP, which was *Management of Comorbid/Coexisting Diseases*. Contractors that had not yet met AHCCCS requirements to complete the previous PIPs (i.e., improved and sustained performance over at least the required two-year remeasurement period) were also required to continue, as applicable, the Children's Oral Health Dental Visits PIP and/or the Immunization Completion Rates by 24 Months of Age PIP.

Mandatory Activities

As permitted by CMS and described in Section 1—Executive Summary, AHCCCS performed the functions associated with the three CMS-mandatory activities that must be performed for the State's Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plan (PIHP) contractors:

- Conduct reviews to determine contractor compliance with standards established by the State which are associated with the applicable federal and State regulations, statutes, rules, and contract requirements
- Validate contractor performance measures
- Validate contractor performance improvement projects (PIPs)

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the activities for its Contractors and to prepare this CMS-required 2006–2007 external quality review annual report of findings and recommendations.

Optional Activities

AHCCCS's EQRO contract with HSAG did not require HSAG to conduct, or to analyze and report results and HSAG's conclusions from AHCCCS having conducted, any CMS-defined optional activities (e.g., validating encounter data, conducting focused studies of health care quality, and assessing information systems capabilities).

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

In its current quality strategy, AHCCCS states that:

- The EQR reports include detailed information about the EQRO's independent assessment process, results, and recommendations.
- AHCCCS uses the information to assess the effectiveness of its current strategic goals and strategies and to provide a roadmap for potential changes and new goals and strategies.

AHCCCS also uses the EQR report findings and recommendations to:

- Support the goals of the national Quality and Cost Transparency Initiatives and AHCCCS's continued development and implementation of its statewide Health Information Exchange and Electronic Health Record central repository (HIE-EHR) and a Web-based system to access and maintain the EHR. The applications are designed to make relevant and timely information

available to Medicaid beneficiaries and providers in a user-friendly format. When fully deployed, the HIE-EHR is expected to improve coordination of member care, enhance opportunities for self-management through personal health information and integrated wellness applications, improve quality of care oversight and transparency through timely performance information, and reduce both medical and administrative costs.

- Drive requirements contained in its Requests for (Contractors) Proposals (RFP) processes.
- Through publishing its EQR annual reports on AHCCCS's Web site, provide members, Contractors, and other stakeholders an opportunity to review and compare Contractor performance and, as applicable to newly enrolled AHCCCS members, to make informed Contractor-enrollment choices.

AHCCCS Statewide Quality Initiatives Across All Medicaid Managed Care Programs

AHCCCS has proven itself to be an innovative leader in identifying and aggressively, proactively pursuing opportunities to improve health care quality and outcomes, as seen in its mission, vision, 2007 QAPI strategy, and five-year strategic plan that began January 1, 2008.

AHCCCS's mission is: "Reaching across Arizona to provide comprehensive, quality health care for those in need." In its 2007 QAPI strategy, the agency describes its vision as "shaping tomorrow's managed health care...from today's experience, quality, and innovation." That vision includes:

- Advocating for customer-focused health care.
- Leading the development of new quality-of-care initiatives and quality improvement strategies.
- Continuing its roles as an innovator of health coverage and as a valued partner and collaborator in improving the health status of Arizonans.
- Expanding its role as a facilitator of collaborative health care initiatives that leverage public and private resources.
- Connecting uninsured and at-risk Arizonans to affordable health care coverage.
- Maintaining its role as a good steward of public and private health care finances.
- Increasing its role as a health information resource.
- Providing an optimal work environment for its employees.

Over time, AHCCCS administration has built its comprehensive quality structure by:

- Designing structures, programs, and initiatives that adhere to federal and State requirements.
- Continuously conducting environmental scans of applicable national standards and national and/or regional trends in such things as population growth and demographics, health status, health care costs, advances in technologies, etc.
- Collaborating with its public and private partners, members, Contractors, and other stakeholders.
- Building on its successes.

AHCCCS uses a participative and collaborative process to identify new clinical and nonclinical initiatives designed to improve quality of care, health outcomes, member satisfaction, and member well-being. AHCCCS ensures that the initiatives are aligned with its overall strategic goals and objectives related to quality, and with its quality improvement processes.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- Identifies priority areas for improvement.
- Establishes realistic outcome-based performance measures.

- Identifies, collects, and assesses relevant data.
- Considers incentives for excellence and imposes sanctions for poor performance.
- Shares best practices with and provides technical assistance to Contractors.
- Includes relevant, associated requirements in its contracts.
- Regularly monitors and evaluates Contractor compliance and performance.
- Maintains an information system that supports initial and ongoing operations and review of AHCCCS's quality strategy.
- Conducts frequent evaluation of the initiatives' progress and results.

AHCCCS implements quality initiatives that are specific to one of its Medicaid managed care programs, as well as quality initiatives that cross all or more than one of its programs and Contractors. Examples of quality initiatives across its programs that AHCCCS had under way during the period covered by this report included, but were not limited to, the following:

- Implementing the Governor's e-Health Roadmap. AHCCCS applied for and was awarded a CMS Medicaid Transformation Grant. Under the grant, AHCCCS is designing and preparing to deploy a statewide health information exchange (HIE) utility, an electronic health record (EHR) central repository, and a Web-based system to access and maintain the EHR.
- Continuing its participation in the "Arizona Health Query." Together with other major Arizona health care providers, AHCCCS is a partner in a health data system that aggregates and analyzes essential, comprehensive health information for Arizona residents that tracks individuals across systems over time.
- Continuing to enhance its data warehouse system to enable end users to quickly access AHCCCS data for a range of quality and medical management studies.
- Participating in the Center for Health Care Strategies (CHCS) grant that focuses on developing the Medicaid pay-for-performance program and a related CHCS grant focused on return on investment designed to evaluate the value of investing in pay for performance.
- Continuing its collaboration with the Arizona Department of Health Services (ADHS) to ensure effective administration and oversight of the federal Vaccines for Children (VFC) program and working with AHCCCS Contractors to ensure that providers ADHS placed on probation provide necessary vaccinations to members.
- Continuing to work collaboratively with the ADHS Office of Environmental Health (OEH) and AHCCCS Contractors to increase member testing for lead and identification of members with elevated blood levels of lead.
- Working with the ADHS Office of Nutrition on a statewide program responsive to the Governor's call to action on childhood obesity. AHCCCS adopted the chronic care model for planning and developing a comprehensive approach to reduce or prevent childhood obesity.
- Collaborating with the Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors.
- Facilitating a collaborative work group focused on members who are seriously mentally ill and have medical complexities to allow the members to live in the community and not at a higher level of care.

AHCCCS Quality Initiatives Driving Improvement for the ALTCS Elderly and Physically Disabled (EPD) and Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Contractors

Examples of AHCCCS's quality improvement initiatives driving improvement for the ALTCS EPD and DES/DDD Contractors included, but were not limited to the following:

- Established new outcome-based performance measures after having solicited Contractor input and AHCCCS internal review and approvals. The new measures will be incorporated into contracts effective October 1, 2008. To the extent possible, the minimum standards and goals that AHCCCS will establish will be based on applicable national and/or State objectives and benchmarks. Examples of the new measures that AHCCCS identified included pressure ulcers (with rates for high-and low-risk members determined overall and by Contractor) and influenza vaccination (including measurement of refusal rates).
- With Contractor input on AHCCCS's proposed methodology, continued its work in developing and implementing an advance directives PIP designed to increase the proportion of long-term care members who have advance directives documented in medical charts or potentially with an Arizona registry maintained by the Secretary of State.
- Hosted an ALTCS EPD and DES/DDD Contractor Administrators meeting that addressed quality-related topics, including notices of action, self-directed attendant care, spouses as paid caregivers, community reintegration, adult dental services, home health nursing issues, transportation for adult day health, electronic medical records, and CYE 2008 contracts.
- Requested and received a waiver from CMS to allow members to select their spouse as their paid caregiver and developed the Spouse as Paid Caregiver Policy, which went into effect in fall 2007.
- Designed a Self-Directed Attendant Care program to enable members to have more control over, and more effectively manage, their care needs.
- Calculated and reported Contractor performance for AHCCCS-selected measures. AHCCCS also required Contractors to submit their CAPs to improve performance for those measures with performance rates that did not reach AHCCCS minimum performance standards.
- Calculated and reported Contractor performance for AHCCCS-required PIPs. AHCCCS required Contractors to submit reports evaluating their data and interventions, and proposing new or revised interventions, if necessary.
- Worked with Contractors to coordinate monitoring and oversight of nursing facilities in the largest Arizona county that:
  - Reduced the burden on nursing facilities by reducing the number of AHCCCS Contractors scheduling and conducting quality management reviews, giving the facilities more time for member care and quality improvement activities.
  - Freed Contractor time and resources to evaluate and improve monitoring and oversight of the home- and community-based program, which, for the most part, has less State licensure oversight.
- Conducted periodic meetings between several AHCCCS divisions and the DES/DDD Contractor that addressed quality management and behavioral health issues and quality-of-care resolution processes. AHCCCS also compiled a document that represented a comprehensive overview of

DES/DDD's performance issues and provided technical assistance to DES/DDD to improve its performance related to these issues and to improve its performance measure rates.

5. Contractor Best and Emerging Practices

Best practices emerge in an environment where continuous quality improvement is embraced, modeled, supported, and rewarded at all levels of an organization. Best practices can be achieved by striving to incorporate evidence-based guidelines into operational structures, policies, and procedures. One method that AHCCCS has used to model and achieve best practices among ALTCS EPD and DES/DDD Contractors is to ensure that the State's organizational assessment and structure standards are at least as stringent as those in Subpart D of the BBA regulations for access to care, structure and operations, and quality measurement and improvement (42 CFR 438.204[g]). Further, the State's verification that Subpart D provisions of the BBA regulations are incorporated in Medicaid contract provisions (42 CFR 438.204[a]) has included standards that directly address:

- Access to care (availability and adequate capacity of services, coordination and continuity of care, and coverage and authorization of services).
- Structure and operations (provider selection, confidentiality, and grievance system).
- Quality measurement and improvement provisions (practice guidelines, quality assessment, performance improvement, and health information systems).

Of particular note is the sharing of best practices among AHCCCS and its Contractors. AHCCCS provides opportunities and forums for regularly sharing best practices with and providing technical assistance to its ALTCS EPD and DES/DDD Contractors. In addition, Contractors are encouraged to share evidence-based best practices with each other and their providers. An example of this is the sharing of successful quality improvement strategies and interventions during AHCCCS Contractor quality management meetings. AHCCCS's use of these meetings as a forum for addressing performance improvement opportunities and initiatives is in itself, a best practice.

AHCCCS's policies and practices reward quality of care, member safety, and member satisfaction outcomes; support evidence-based best practices in disease management and preventive health; provide feedback on quality and outcomes to Contractors and providers; and provide for strategic, periodic monitoring of a wide variety of processes and outcomes. As part of its five-year goals, AHCCCS has adopted the following tenets:

- Enhancing current performance measures, performance improvement projects, and best practices activities by creating a comprehensive quality-of-care assessment and improvement plan across AHCCCS Medicaid programs that serves as a roadmap for improvement of member-centered outcomes
- Continuing the use of nationally recognized protocols, standards of care, and benchmarks
- Continuing the use of a system of rewards for providers, in collaboration with its Contractors, based on clinical best practices and outcomes
- Developing collaborative strategies and initiatives with other State agencies and with external partners, including the following:
  - Engaging in strategic partnerships to improve access to health care services and affordable health care coverage

- Collaborating with Contractors and providers on best practices in disease prevention and health maintenance

The results of AHCCCS's leadership in developing and promoting systems and cultures of best practices across Contractors can be seen through one outcome of the Management of Comorbid Diseases PIP. Practice guidelines and protocols have been developed with both outcomes and cost efficiency as principal concerns. Effective practice guidelines commonly used in disease management programs may lead to reduced inpatient and emergency room utilization and changes in patient care patterns. At this point in the PIP, substantively large increases have been evidenced in the median number of outpatient encounters. Corresponding decreases in the median numbers of ER/UC visits and inpatient days could be seen by the next measurement cycle. A review of the various interventions employed by ALTCS EPD Contractors identified two underlying, emerging practices: enhanced care coordination and assessment activities.

Regarding other AHCCCS and Contractor activities, CYE 2007 saw the implementation of best practices that included the following:

- Increased emphasis on improving staff members' cultural and linguistic skills through annual or ongoing cultural sensitivity training
- Implemented provider compliance rewards for performance excellence
- Conducted regular screenings of members for behavioral health needs to proactively identify at-risk members and to coordinate referrals and care as appropriate
- Implemented a telemonitoring pilot program for members with a high number of inpatient and ER encounters, and developed internal tracking databases capable of capturing member needs, diseases, and interactions with care providers—interventions that capitalized on emerging technologies available to enhance the management of patient care
- Modified existing organizational structures to create staff positions that specialized in coordinating care for members with complex and/or coexisting diseases, and set up multidisciplinary teams to address members with special health care needs
- Conducted a provider survey with PCPs to ensure that members with chronic conditions (e.g., diabetes) received care provided in alignment with best practice guidelines
- Continued to enhance electronic systems and capabilities for collecting, reporting, analyzing, and sharing data and other information to more effectively:
  - Monitor performance
  - Identify systemwide and individual Contractor- and provider-specific best and effective practices
  - Identify systemwide and individual Contractor- and provider-specific performance deficits
  - Target quality improvement activities and interventions to ensure that the highest quality of care and services are provided to members, and that members are satisfied with the care and services they receive

In addition to improvements related to CYE 2007 PIPs, substantive and significant improvements were also seen in most of the performance measures. More importantly, the Contractor aggregate performance measure rates all exceeded AHCCCS minimum performance standards and goals. The Contractors were, therefore, collectively forming emerging best practices across the State. A review

of the Contractor strategies showed a variety of approaches that served to increase communication with both providers and members. Among the strategies employed by ALTCS EPD and DES/DDD Contractors were:

- Enhanced educational outreach focused on providing members with detailed information on chronic conditions (e.g., diabetes) and self-management guidelines.
- Improved monitoring and surveillance of member utilization to facilitate coordination with ongoing disease and case management programs, and informed PCPs when members were due for specific preventive services.
- Distributed practice guidelines to PCPs.
- Revised provider contracts to incorporate requirements that ensure members regularly visit physicians to increase the rates of preventive screenings.

HSAG has described additional best and emerging practices and programs undertaken and planned by AHCCCS and its Contractors in Section 2—Background, which includes a discussion of AHCCCS's quality strategy and the associated activities, and Section 4—AHCCCS Quality Initiatives.

Overall, AHCCCS and the Contractors are succeeding in instilling a culture of quality improvement with results that confirm the effectiveness of the program. Using extensive monitoring and aggressive CAPs, the reported quality indicator rates have generally improved, some by substantial amounts. Through the organizational assessment and structure standards review, the performance measures, and the PIPs, AHCCCS and the ALTCS EPD and DES/DDD Contractors are improving timely access to quality care for their Medicaid members.

6. Organizational Assessment and Structure Performance

State Medicaid and licensing agencies, private accreditation organizations, and the federal Medicare program all recognize that having standards is only the first step in promoting safe, accessible, timely, and quality services. The second step is ensuring compliance with the standards.

According to 42 CFR 438.358, which describes activities related to external quality reviews, the state Medicaid agency, its agent that is not an MCO or PIHP, or an EQRO must conduct a review within a three-year period to determine MCOs' and PIHPs' compliance with state standards. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described at 42 CFR 438 that address requirements related to access, structure and operations, and measurement and improvement.

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' performance in complying with federal and State requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the BBA mandatory compliance review activity. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1-5), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its compliance review activities to prepare this 2006–2007 annual external quality review report.

Conducting the Review

The 2006–2007 OFR began a new three-year cycle of AHCCCS OFRs. AHCCCS conducted an extensive review of the ALTCS EPD and DES/DDD Contractors' performance to assess their compliance with federal and State laws, rules and regulations, and the AHCCCS contract. AHCCCS assessed Contractors' compliance with standards in 11 performance areas:

- General Administration
- Delivery System
- Grievance Systems
- Case Management
- Behavioral Health
- Medical Management
- Quality Management
- Maternal and Child Health
- Financial Management
- Claims System
- Encounters

Objectives for Conducting the Review

AHCCCS's objectives for conducting the OFR were to:

- Determine if the Contractors satisfactorily met AHCCCS's requirements as specified in their contract, AHCCCS policies, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR).
- Increase AHCCCS's knowledge of the Contractors' operational and financial procedures.
- Provide technical assistance and identify areas where Contractors can improve and areas of noteworthy performance and accomplishments.
- Review the Contractors' progress in implementing recommendations AHCCCS made during prior OFRs.
- Determine if the Contractors complied with their own policies and evaluate the effectiveness of those policies and procedures.
- Perform Contractor oversight as required by CMS in accordance with AHCCCS's 1115 waiver.
- Provide information to HSAG as AHCCCS's EQRO for its use in preparing this report as described in 42 CFR §438.364.

HSAG designed a summary tool to:

- Organize and represent the information AHCCCS presented in the nine ALTCS EPD and DES/DDD individual Contractor reports that documented each Contractor's performance in complying with the operational and financial standards.
- Facilitate a comparison of the Contractors' performance.

The summary tool focused on the objectives of HSAG's analysis, which were to:

- Determine each Contractor's compliance with standards established by the State to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
- Provide data from the review of each Contractor's compliance with the standards that would allow HSAG to draw conclusions as to the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide, across the Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and across Contractors.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts an annual, formal operational and financial review (OFR) of each Contractor. AHCCCS follows a CMS-approved process to conduct the OFRs that is also consistent with CMS' protocol for EQROs that conduct the reviews—i.e., the February 11, 2003, Final Protocol (Version 1.0), *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Contractors (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR, Parts 400, 430, et. al.

Beginning a new three-year cycle of OFRs, AHCCCS conducted an extensive review of Contractor performance in meeting standards. AHCCCS provided the Contractors with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review and (2) a list of documents and information that was to be available to AHCCCS for its review during the OFR on-site review process.

AHCCCS's methodology was consistent across all Contractors and included the following:

- Desk review activities that AHCCCS conducted prior to its on-site review to minimize the time needed on-site and to begin its assessment of the Contractors' performance by reviewing documents Contractors were required to submit to AHCCCS.
- On-site review activities that included AHCCCS reviewing additional Contractor documentation and conducting interviews with key Contractor administrative and program staff. Reviews generally required three to five days, depending on the extent of the review and the location of the Contractor.
- Activities AHCCCS conducted following the on-site review, including:
  - Documenting and compiling the results of its reviews, preparing the draft reports of findings, and issuing the draft reports to the Contractors for their review and comment. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS's review findings and assessment of the degree to which the Contractor was in compliance with the standards. Full Compliance was 90 to 100 percent compliant, Substantial Compliance was 75 to 89 percent compliant, Partial Compliance was 50 to 74 percent compliant, and Non-Compliance was 0 to 49 percent compliant. If a standard was not applicable to a Contractor, AHCCCS noted this using an N/A designation. The reports sent to the Contractors also included, when applicable, any AHCCCS recommendations, which were stated as:
    a. *The Contractor must*….This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
    b. *The Contractor should*….This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the everyday operation of the Contractor.
    c. *The Contractor should consider*….This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.
- Reviewing and responding to any Contractor challenges to AHCCCS's draft report findings and, as applicable based on its review of the challenges, revising the draft reports.
- Issuing the final Contractor reports describing the findings, scores, and, as applicable, required Contractor CAPs for each standard AHCCCS reviewed.

AHCCCS's review team members included employees of the Division of Health Care Management (DHCM)–ALTCS, Operations, Finance, Data Analysis and Research, Medical Management and Clinical Quality Management units, and the Office of Administrative Legal Services.

AHCCCS's review activities conform to the CMS requirement to assess each Contractor on the extent to which it addressed recommendations for quality improvement AHCCCS made as a result

of its findings from the previous year's review. Fundamental to this process, AHCCCS requires its Contractors to propose formal CAPs—and have them accepted by AHCCCS—for deficiencies in the Contractor's performance that AHCCCS identified as part of its ongoing monitoring and/or formal annual OFR processes.

From its review of the Contractors' CAPs and associated documentation, AHCCCS determines if:

- The activities and interventions specified in the CAPs could reasonably be anticipated to correct the deficiencies AHCCCS identified during the OFR (or other monitoring activity) and bring the Contractor back into compliance with the applicable AHCCCS standards.
- The documentation demonstrates that the Contractor had implemented the required action(s) and is now in compliance with one or more of the standards requiring a CAP.
- Additional or revised CAPs or documentation are still required from the Contractor for one or more standards and the CAP process remains open and continuing.

AHCCCS follows up on each Contractor's implementation of the CAPs and related outcomes during its ongoing monitoring and oversight activities as well as during future OFRs. These activities determine whether the corrective actions were effective in bringing the Contractor back into compliance with AHCCCS requirements.

Following a preliminary review of AHCCCS's documentation of its OFR findings, and to ensure that HSAG was using complete and accurate information in preparing the annual report, HSAG developed and provided to AHCCCS a list of questions or requests for clarification related to AHCCCS's documentation and data. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this 2006–2007 annual report.

Using the verified results AHCCCS obtained from conducting the OFRs, HSAG organized and aggregated the performance data and the required CAPs for each Contractor and across the Contractors. HSAG then analyzed the data by performance area (e.g., Quality Management, Behavioral Health, and Claims Systems) and by each of the individual standards within an area.

Based on its analysis, HSAG drew conclusions about the quality and timeliness of, and access to, care and services provided by each Contractor and statewide across Contractors. HSAG identified data-driven Contractor performance strengths and, where applicable, opportunities for improvement. When HSAG identified opportunities for improvement, it also provided recommendations to improve the quality and timeliness of, and access to, the care and services Contractors provide to AHCCCS members.

Contractor-Specific Results

AHCCCS conducted an extensive OFR for eight ALTCS EPD Contractors and for the DES/DDD Contractor, separately discussed. AHCCCS reviewed the Contractors' performance on 110 to 123 compliance standards, depending upon the Contractor.[6-1] The percentage of these standards with performance in full compliance with requirements ranged from 67 percent to 89 percent across the Contractors. Separate results for each of the Contractors are presented next.

[6-1] Differences in the number of standards reviewed were due to some standards being not applicable to specific Contractors. For example, this year's review did not assess compliance with the Encounter standards for Bridgeway Health Solutions and SCAN Long Term Care, two new Contractors.

Bridgeway Health Solutions

Bridgeway Health Solutions (B'Way) serves eligible, enrolled members in Maricopa, La Paz, and Yuma counties and has contracted with AHCCCS since October 1, 2006. At the time of this review, the Contractor had approximately 1,065 members. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed B'Way's staff at work.

Findings

Figure 6-1 presents the overall compliance results (i.e., far-left bar) and the results for each of 10 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-1—Categorized Levels of Compliance With Technical Standards for B'Way[6-2]

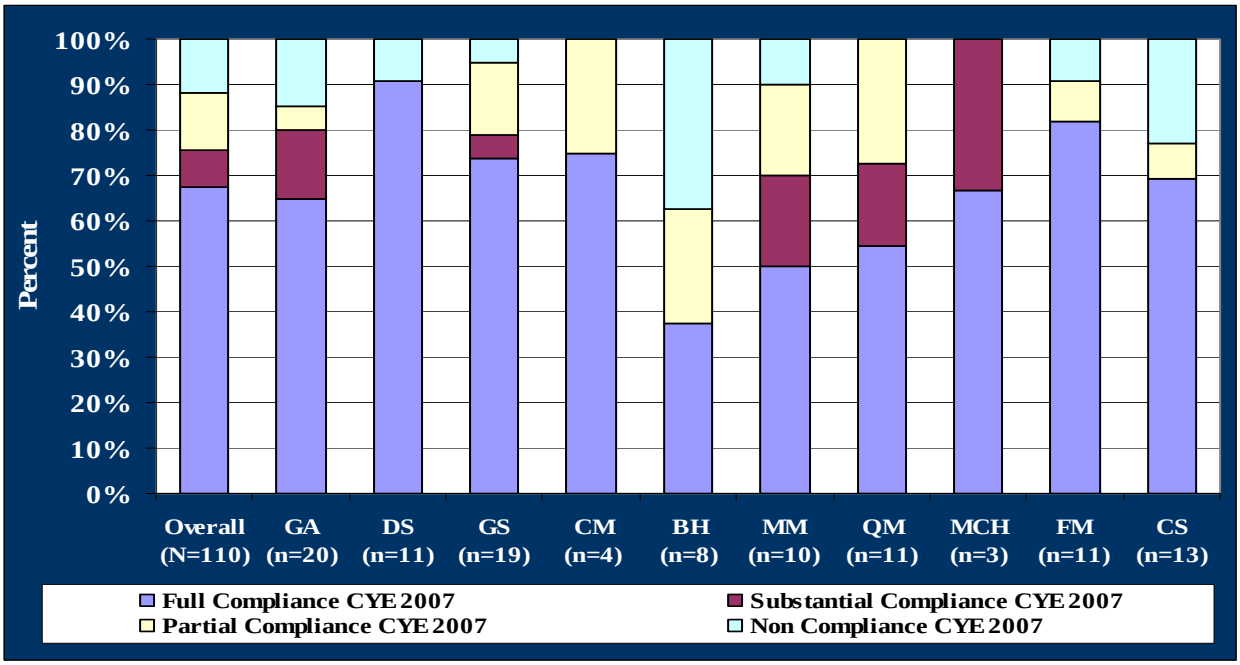


Figure 6-1 shows that B'Way was in full compliance for 67 percent of the 110 reviewed standards (left-most bar) with a large variation in performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Delivery Systems category. AHCCCS scored only one standard as less than fully compliant, representing 9 percent of the standards in this category. This noncompliant standard addresses the timeliness of notifying members when a provider leaves the network, and represents an opportunity for improvement.

[6-2] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, and CS=Claims System.

Proportional to the number of standards within each category, the Behavioral Health category shows the greatest opportunity for improvement. Of the 10 categories of standards, the Behavioral Health category showed the lowest percentage of standards in full compliance (38 percent) and the highest percentage in noncompliance (38 percent). Other categories with less than 60 percent of the reviewed standards in full compliance include Medical Management (50 percent) and Quality Management (55 percent). These three categories suggest important opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Financial Management category for B'Way. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-1 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-1—Corrective Action Plans By Category for B'Way

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	7	19%	20	35%
Delivery Systems	1	3%	11	9%
Authorization & Denial/Grievance Systems	5	14%	19	26%
Case Management	1	3%	4	25%
Behavioral Health	5	14%	8	63%
Medical Management	5	14%	10	50%
Quality Management	5	14%	11	45%
Maternal/Child Health	1	3%	3	33%
Financial Management	3	8%	11	27%
Claims System	4	11%	13	31%
Overall	**37**	**100%**	**110**	**34%**

Table 6-1 shows the largest number of required CAPs (seven) was associated with the General Administration category. Although this finding was somewhat influenced by the relatively large number of standards within the category (20), the General Administration category results identify a clustering of opportunities for improvement for the Contractor. Additionally, at least one CAP was required within each of the 10 categories of standards for B'Way. Of those categories with at least eight reviewed standards, the Behavioral Health, Medical Management, and Quality Management categories required a CAP for at least 45 percent of the standards in each category. Overall, more than one-third (34 percent) of compliance standards reviewed in CYE 2007 resulted in a required CAP for B'Way.

Strengths

The results for the Delivery Systems category show it to be an area of strength for B'Way. Only one of the 11 standards (9 percent) in the category required a CAP (i.e., Contractor should develop a policy and a process regarding notification of affected members in a timely manner when a provider leaves the network).

Opportunities for Improvement and Recommendations

With at least one required CAP in each of the 10 categories of standards, the results provide evidence of widespread opportunities for improvement. In the final report generated from B'Way's OFR, AHCCCS included a detailed list of recommendations at both the standard and category levels. A review of these recommendations highlights two key themes that underlie the opportunities for improvement across multiple categories—i.e., improved communication with members and providers and enhanced monitoring of B'Way's processes and procedures. For example, AHCCCS recommended that B'Way work to formalize processes for communicating provider assignment and changes to members (General Administration and Delivery Systems) and notifying "case managers and providers on consultation requirements" (Behavioral Health). This recommendation indicates the need to develop a systemwide approach to enhanced communication that focuses on both disseminating information as well as receiving feedback. AHCCCS also recommended that B'Way work to improve its monitoring of "network and appointment requirements" (Behavioral Health) and EPSDT compliance by providers (Maternal/Child Health). Again, establishing a comprehensive strategy of monitoring performance in all operational areas will not only ensure B'Way's improved compliance with AHCCCS standards, but lead to more efficient operations.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: General Administration, Behavioral Health, Medical Management, and Quality Management.

- **General Administration:** From the perspective of member access (one of the three BBA aspects of care), B'Way's performance in the General Administration category would benefit from the development and operationalization of a systemwide focus on reaching out to, informing, and seeking feedback from its members, providers, and employees. Of the 20 standards reviewed in this category, 5 standards (25 percent) were related to cultural competency, of which 2 standards (40 percent) required a CAP. Although AHCCCS's OFR findings noted that B'Way had a cultural competency program, deficiencies were noted in: (1) the degree to which members were made aware of cultural competency programs on an ongoing basis and (2) the degree to which B'Way sought feedback on its cultural competency plan from key stakeholders. B'Way should invest resources in developing a comprehensive and fully recursive model of communication that not only ensures members receive appropriate, relevant, and timely information regarding the cultural competency program and how to access services, but also to obtain feedback regarding potential barriers that prevent or make it difficult to access or provide services.
- **Behavioral Health:** A central construct across the standards requiring a CAP in the Behavioral Health category is coordination of care. Coordination of care impacts all three BBA aspects of care: quality, timeliness, and access. Strategic improvement of coordination of care would likely

improve performance for all five of the review standards requiring a CAP. B'Way should consider evaluating its current approaches to ensuring performance in coordinating member care and services, including whether enhanced and/or additional strategies are required. The evaluation should determine if the results that were less than fully compliant were a product of provider failure to coordinate the care, a failure to document the coordination, or a combination of both. One potentially effective strategy for enhancing performance is for B'Way to strengthen the processes and resources available to providers for appropriately sharing electronic health/medical records among providers and case managers. This action may result in improved coordination between providers and improved member care and services through enhanced communication.

- **Medical Management:** The predominant opportunities for improvement within this category were related to improving B'Way's organizational structure for utilization monitoring, feedback, and procedural compliance with AHCCCS's medical management contractual requirements. Importantly, scientific rigor within the quality improvement process is the central aspect of the Medical Management standards requiring a CAP. The advantages to B'Way for developing its capacity for scientific rigor and incorporating the resulting information with the quality improvement process should not only resolve most of the Medical Management CAPs, but should also show benefits in using the acquired information for targeted improvement projects, such as PIPs.
- **Quality Management:** The required CAPs for this category focus on member protection. These CAPs aim to resolve low performance on standards related to: oversight and accountability for quality functions, including peer review; tracking and trending member abuse complaints and resolutions; and protecting basic member rights. From a BBA perspective, these are core areas for improving the quality of member care and services. B'Way should consider designing and implementing more formalized structures to generate, share, and act on quality management information. Activities should include implementing strategies to develop written policies and procedures that reflect AHCCCS standards and best practices.

Summary

B'Way was a new ALTCS EPD Contractor during AHCCCS's current review cycle, which may account, in part, for the proportionately large number of required CAPs. Delivery Systems was the only category of standards with a score above 90 percent in full compliance (91 percent). The categories for Behavioral Health, Medical Management, and Quality Management show considerable opportunities for improvement, with at least 45 percent of the reviewed standards from each category in less than full compliance.

Cochise Health Systems

Cochise Health System (CHS) serves eligible, enrolled members in Cochise, Graham, and Greenlee counties and has contracted with AHCCCS since 1993. At the time of this review, the Contractor had approximately 900 members. During the OFR, the review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed CHS's staff at work.

Findings

Figure 6-2 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-2—Categorized Levels of Compliance With Technical Standards *for* CHS[6-3]

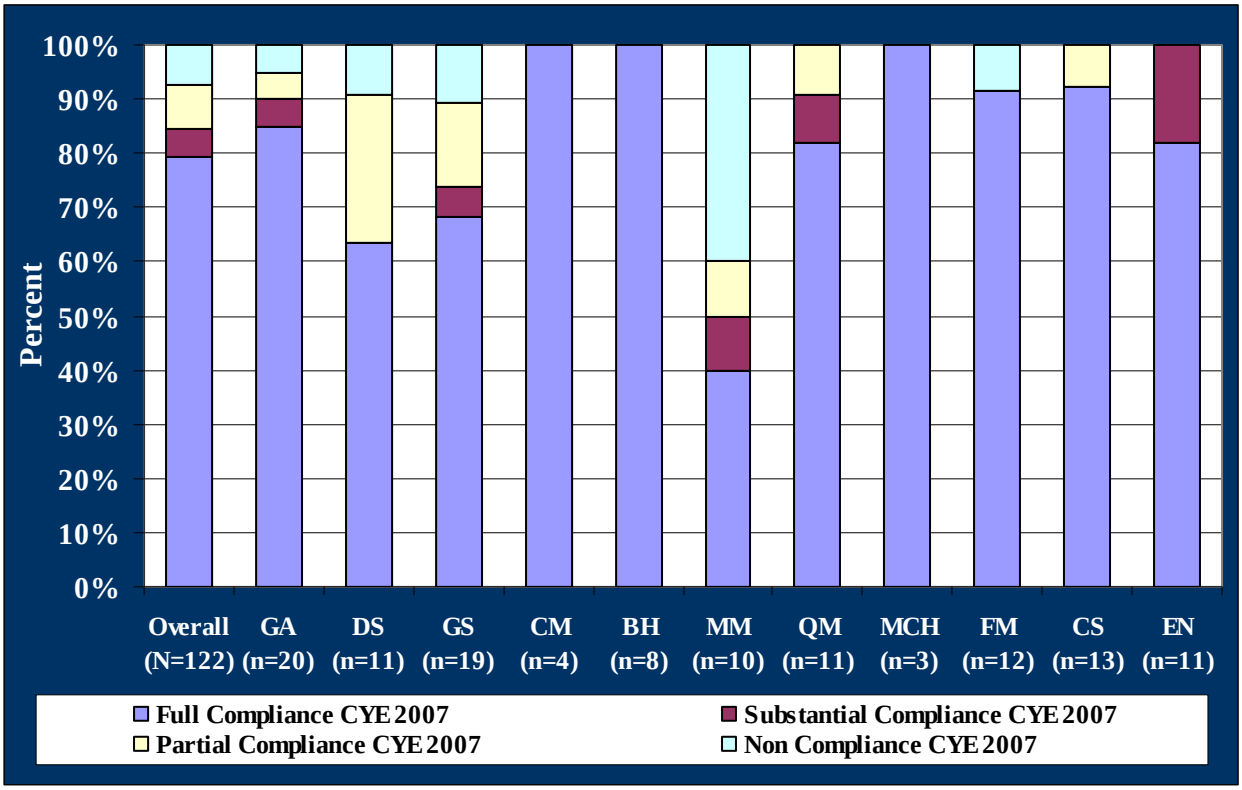


Figure 6-2 shows that CHS was in full compliance for 80 percent of the 122 reviewed standards (left-most bar) with a large variation in performance across the categories of standards. The Contractor's strongest performance was for standards associated with Case Management, Behavioral Health, and Maternal/Child Health, for which 100 percent of the standards were

[6-3] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

assessed as fully compliant. Additionally, the standards within the Financial Management and Claims Systems categories were each assessed with more than 90 percent of the standards in full compliance, while the General Administration, Quality Management, and Encounters categories were each assessed with slightly more than 80 percent of the standards in full compliance.

Proportional to the number of standards within each category, the standards within Medical Management presented the greatest opportunity for improvement, with only 40 percent of the reviewed standards in full compliance. This category was followed by Delivery Systems and Authorization and Denial/Grievance Systems, where 64 percent and 68 percent of the reviewed standards were in full compliance, respectively.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-2 presents the number and proportion of CAPs required within and across the categories of the compliance standards reviewed for CYE 2007.

Table 6-2—Corrective Action Plans By Category for CHS

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	3	12%	20	15%
Delivery Systems	4	16%	11	36%
Authorization & Denial/Grievance Systems	6	24%	19	32%
Case Management	0	0%	4	0%
Behavioral Health	0	0%	8	0%
Medical Management	6	24%	10	60%
Quality Management	2	8%	11	18%
Maternal/Child Health	0	0%	3	0%
Financial Management	1	4%	12	8%
Claims System	1	4%	13	8%
Encounters	2	8%	11	18%
Overall	**25**	**100%**	**122**	**20%**

Table 6-2 shows that almost half (12 of 25) of the required CAPs for CHS are evenly divided between the Authorization and Denial/Grievance Systems category and the Medical Management category. These CAPs are associated with 32 percent and 60 percent, respectively, of the standards in each of these categories. Notably, three categories did not require any CAPs (Case Management, Behavioral Health, and Maternal/Child Health), and two categories required only one CAP (Financial Management and Claims System). Overall, one-fifth (20 percent) of the compliance standards reviewed for CHS in CYE 2007 resulted in a required CAP.

Strengths

All of the standards reviewed within the Case Management, Behavioral Health, and Maternal/Child Health categories were assessed by AHCCCS as being in full compliance with requirements. However, these three categories (27 percent, or 3 of 11 categories) represented only 12 percent of the total standards reviewed (15 of 122 standards). Strengths were also noted for standards within the Financial Management and the Claims Systems categories, totaling two CAPs (8 percent of all CAPs) with 20 percent of all reviewed standards (25 of 122 standards). Proportionately, the reviewed standards within General Administration were also a strength, with just three CAPs (12 percent of all CAPs) and 16 percent of all reviewed standards (20 of 122 standards).

Opportunities for Improvement and Recommendations

In the final report generated from CHS's OFR, AHCCCS included a detailed list of recommendations at both the standard and category levels. A review of these recommendations highlights two key themes that underlie the opportunities for improvement across multiple categories, including improving internal policies and procedures and communication with members and providers, and enhanced monitoring of CHS's processes and procedures. For example, AHCCCS recommended that CHS work to formalize processes for communicating with members and providers with timely notifications (Authorization and Denial/Grievance Systems and Delivery Systems) and ensuring policies are complete and accurate (Medical Management, Delivery Systems, and Authorization and Denial/Grievance Systems). These recommendations indicate the need to develop a systemwide approach to enhanced communication that focuses both on disseminating information as well as making sure policies and procedures accurately reflect contract requirements. AHCCCS also recommended that CHS work to improve its monitoring of member utilization and internal systems (Medical Management). Establishing a comprehensive strategy of improvement in all organizational areas will not only ensure CHS's improved compliance with AHCCCS standards, but lead to more efficient operations.

HSAG's review supports these recommendations and includes the following additional recommendations for the areas with the greatest opportunity for improvement: Delivery Systems, Authorization and Denial/Grievance Systems, and Medical Management.

- **Delivery Systems**: Three of the four CAPs that indicated opportunities for improvement were related to member access to the timely delivery of quality care. The CAPs were for the standards requiring: (1) timely notifications of physicians leaving the network, (2) contractors not prohibiting/restricting providers from advising/advocating on behalf of their member-patients, and (3) contractors referring members to out-of-network providers if they are unable to provide services within the network. In its quality management and performance improvement (QM/PI) plan for CYE 2007, CHS stated that it was "committed to contracting with health care providers that deliver cost-effective, medically appropriate care, and whose services are readily accessible to our members regardless of payer source or eligibility category" (pg. 2). HSAG recommends that CHS incorporate this statement into a corporate-wide philosophy to improve the performance for standards that were assessed as not in full compliance with requirements. Specifically, established quality committees should implement periodic reporting and ongoing monitoring of the timeliness of member notifications when physicians are leaving the network. Although current processes include contacting members by phone, written notification was

inconsistent and incomplete. Second, policies, procedures, and operational principles should all be reviewed and aligned with BBA and AHCCCS contract language and requirements to ensure that providers feel supported when advocating for their member-patients and when making appropriate referrals to out-of-network providers. The fourth CAP was for the standard requiring Contractors to submit written notification of the reasons that a contract with a provider had been declined.

- **Authorization and Denial/Grievance Systems**: Almost one-third of the reviewed standards in this category (6 of 19) required a CAP. Five of the six CAPs were related to processes involved with authorizations (prior and continued-stay). This finding suggests an opportunity to improve an aspect of care that is central to the health and satisfaction of members. Prior authorizations and continued-stay authorizations should have policies, processes, procedures, and points-of-contact available to all members and providers. The relevant materials should be made available in a variety of media (Web sites, printed brochures, etc.), across provider settings (physician offices) and in culturally and linguistically appropriate formats. HSAG recommends that CHS convene a time-limited work group to review, evaluate, and implement strategic changes in current policies and procedures to move toward full alignment with AHCCCS contract requirements. A schedule of regular reviews by an interdepartmental review team can also be used to monitor and make recommendations regarding how well CHS's policies and procedures reflect current State and federal guidelines. The sixth CAP in this category was for the requirement that Contractors ensure that individuals making decisions on grievances and appeals are appropriately qualified. The CAP specifies that the individual who makes a decision on an appeal should not be involved in any previous level of review or decision making. It is expected that this CAP can be expeditiously resolved by implementing an appropriate system of checks and balances. CHS should use its appropriate quality committee to review the current process for managing the grievance and appeal process with the goal to establish a system in full compliance with AHCCCS contract requirements. This includes establishing appropriate levels of review, oversight, and second-level reviews such that multiple individuals are involved in reviewing grievance and appeal cases. A multitiered review process ensures: (1) that members receive a fair review and (2) the integrity of the overall process.
- **Medical Management**: With 60 percent (6 out of 10 standards) of the reviewed standards requiring a CAP, the Medical Management category represents an area with an overall opportunity for improvement. The predominant opportunities for improvement included improving the organizational structure for monitoring and analyzing utilization and observed variances in utilization, developing methods and procedures for evaluating existing disease management programs, enhancing policies for applying medical necessity criteria for inpatient stays, and procedural compliance with AHCCCS medical management contractual requirements. In general, HSAG recommends convening an interdepartmental team to evaluate the current structure of the Medical Management committee. The focus of this work group should be to ensure that the Medical Management committee is used as an efficient medium to review the overall management of member care and make recommendations for improvement based on scientific evidence. In many cases, reporting structures were already in place for evaluating CHS's delivery of care; however, documentation of committee actions and decisions was lacking. Scientific rigor within the quality improvement process is another central aspect of the Medical Management standards that required a CAP. Developing the capacity for scientific rigor and the incorporation of the resulting information into the quality improvement process should resolve many of the CAPs within the Medical Management category. It should also show

benefits for quality improvement projects (e.g., PIPs) and program expansion by using the acquired information to guide the development of quality activities.

Summary

The results for CHS showed strength in the Case Management, Behavioral Health, and Maternal/Child Health categories. Further, the Financial Management and the Claims Systems categories exhibited full compliance with technical standards in excess of 90 percent. Nonetheless, these successes are tempered by opportunities for improvement within the Delivery Systems, Authorization and Denial/Grievance Systems, and Medical Management categories.

Evercare Select

Evercare Select (ES) serves eligible, enrolled members in Maricopa, Mohave, Coconino, Apache, and Navajo counties and has contracted with AHCCCS since October 1, 1989. At the time of this review, the Contractor had approximately 5,100 members. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed ES's staff at work.

Findings

Figure 6-3 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-3—Categorized Levels of Compliance With Technical Standards *for* ES[6-4]

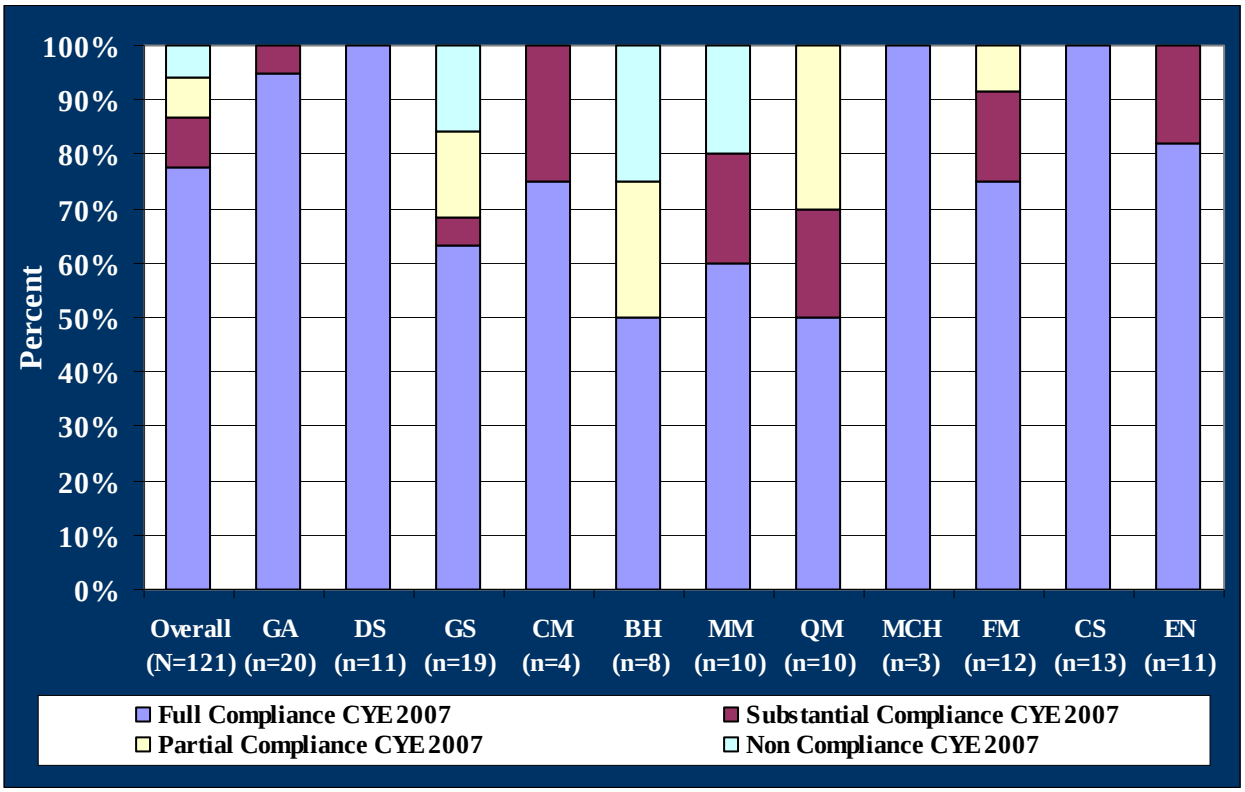


Figure 6-3 shows ES in full compliance for 78 percent of the 121 reviewed standards (left-most bar) with a large variation in performance across the categories of standards. The Contractor's strongest performance was for standards associated with the Delivery Systems, Maternal/Child Health, and

[6-4] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

Claims System categories. All standards in these categories were assessed in full compliance. Additionally, more than 90 percent of the standards within the General Administration category were assessed as fully compliant.

Proportional to the number of standards within each category, the standards within Behavioral Health and Quality Management presented the largest opportunities for improvement, with only 50 percent of the reviewed standards in full compliance for both categories. These categories were followed by the Medical Management and Authorization and Denial/Grievance Systems categories, where 60 percent and 63 percent of the reviewed standards were in full compliance, respectively.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-3 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-3—Corrective Action Plans By Category for ES

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	1	4%	20	5%
Delivery Systems	0	0%	11	0%
Authorization & Denial/Grievance Systems	7	26%	19	37%
Case Management	1	4%	4	25%
Behavioral Health	4	15%	8	50%
Medical Management	4	15%	10	40%
Quality Management	5	19%	10	50%
Maternal/Child Health	0	0%	3	0%
Financial Management	3	11%	12	25%
Claims System	0	0%	13	0%
Encounters	2	7%	11	18%
Overall	**27**	**100%**	**121**	**22%**

Table 6-3 shows that 44 percent (12 out of 27) of the required CAPs for ES were within the Authorization and Denial/Grievance Systems and the Quality Management categories. These CAPs represented 37 percent and 50 percent, respectively, of the standards in these categories. Additionally, the Behavioral Health and Medical Management categories showed required CAPs for 50 percent and for 40 percent of their reviewed standards, respectively. Notably, three categories did not require any CAPs (Delivery Systems, Maternal/Child Health, and Claims System), and two categories required only one CAP (General Administration and Case Management). Overall, slightly more than one-fifth (22 percent) of the compliance standards reviewed for ES in CYE 2007 resulted in a required CAP.

Strengths

All of the reviewed standards for the Delivery Systems, Maternal/Child Health, and Claims System categories were assessed by AHCCCS as being in full compliance with the State's technical standards. Strengths were also identified with the General Administration and Case Management categories. These categories represented 20 percent of the reviewed standards (24 of 121 standards), for which ES was only required to complete two CAPs.

Opportunities for Improvement and Recommendations

In the final report generated from ES's OFR, AHCCCS included a detailed list of recommendations at both the standard and category levels. A review of these recommendations highlights several key themes that underlie the noted opportunities for improvement across multiple categories—i.e., enhanced communication with members and providers, improved monitoring, and developing comprehensive policies and procedures. For example, AHCCCS recommended that ES enhance communication to members and providers (Authorization and Denial/Grievance Systems, Behavioral Health, and Quality Management) and include feedback opportunities (Quality Management). Recommendations also included modifying existing documents to ensure they are written in commonly understood language. These recommendations indicate the need to develop a systemwide approach to effective policymaking that focuses on drafting documents that are in alignment with AHCCCS requirements and written in commonly understood language. Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas will not only ensure ES's improved compliance with AHCCCS standards, but lead to more efficient operations. Additionally, AHCCCS recommended that ES work to improve its monitoring of member utilization and internal systems (Medical Management).

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Authorization and Denial/Grievance Systems, Behavioral Health, Medical Management, and Quality Management.

- **Authorization and Denial/Grievance Systems**: More than one-third of the reviewed standards in this category (7 of 19) required a CAP, and the CAPs were for the first 7 standards in the category (GS1-GS7). These standards describe the Contractor's required timing and interactions for prior authorizations, continued-stays, and member-specific information involving member rights with respect to authorization decisions. This finding suggests an opportunity to improve this aspect of care that is central to member health and satisfaction. Prior authorizations and continued-stay authorizations should be rooted in clear and concise policies, processes, and procedures. Further, points-of-contact should be published and readily available to all members and providers. To facilitate coverage, relevant materials should be produced and distributed through a variety of media (i.e., Web sites, printed brochures, etc.), across various provider settings (physician offices), and written in culturally and linguistically appropriate formats. Overall, HSAG recommends that a work group be convened to review current policies and procedures and ensure that ES meets AHCCCS's contractual requirements. Additionally, all written member and provider notices should be updated to ensure that they align with all State and federal requirements. Finally, ES should identify an appropriate committee for completing an annual review of all written materials to maintain compliance with AHCCCS standards related to authorizations and grievances.

- **Behavioral Health**: Within the Behavioral Health category, two constructs underlie the compliance standards that required a CAP: coordination of care and improved screening for behavioral health concerns. Both of these themes (i.e., care coordination and enhanced screening) have important ramifications for all three BBA dimensions of care: quality, timeliness, and access. The strategic merging of these constructs into viable interventions would likely improve performance for all four of the reviewed standards that required a CAP. Several methods exist for unifying behavioral health improvement efforts, revolving around shared methods that capitalize on opportunities for screening and subsequently taking appropriately rapid action to address results. For example, the implementation or enhancement of electronic health/medical records could include systems for timely provider notifications that work to open and maintain communication between providers and case managers and result in more coordinated and timely treatment. Further, this type of shared information system should be able to facilitate and document the appropriate transfers of information and referrals of members in a manner that would resolve the present CAPs.
- **Medical Management**: The predominant opportunity for improvement within this category was an improved organizational structure for monitoring utilization, processing and acting upon feedback and data, and implementing the recommendations from the Medical Management Committee. Although ES has implemented some level of reporting related to members' utilization, current information was insufficient and not well integrated into the Medical Management Committee structure and used throughout the organization. Therefore, ES should work to include utilization review and provider follow-up in its ongoing activities. Further, these activities should be clearly documented in the committee's meeting minutes. ES should also work to bring scientific rigor to its medical management activities. By developing the capacity for scientific rigor, ES will be able to integrate generated information directly into the quality improvement process. Specifically, HSAG recommends pulling together a time-limited work group of interdepartmental experts to review and recommend methods for analyzing utilization data and for monitoring the delivery of services. This work group should also be responsible for implementing a comprehensive interrater reliability program in order to ensure clinical decisions are made consistently and accurately. In addition to addressing AHCCCS standards, an increase in scientific rigor would be expected to lead to benefits in complementary areas such as PIPs.
- **Quality Management**: The required CAPs for this category focused on member protection and quality improvement and included the following standards that were not found to be in full compliance: oversight and accountability for quality functions, including peer-review; quality-of-care intervention and resolution; a process for improving performance measure results; a process for verifying the credentials of organizational providers; and a guarantee of basic member rights. Each of these areas represented an opportunity for improvement and was related to all three dimensions of care (quality, access, and timeliness). To address these areas, ES should consider more formalized structures to generate, share, and act on quality management information. HSAG suggests ES evaluate current committee structures to identify appropriate steps for enhancing current operations. This internal review should include, at a minimum, an evaluation of current meeting documentation practices, a comparative crosswalk between AHCCCS requirements and current committee responsibilities, and the level of scientific sophistication with which quality-of-care issues are identified, monitored, and acted upon. Further, ES would benefit from improved communication processes with both members and providers.

Summary

The results for ES showed strengths in the Delivery Systems, Maternal/Child Health, and Claims System categories. Further, the General Administration category indicated full compliance for more than 90 percent of the reviewed standards. Nonetheless, these successes are tempered by opportunities for improvement within the Authorization and Denial/Grievance Systems, Behavioral Health, Medical Management, and Quality Management categories.

Mercy Care Plan

Mercy Care Plan (MCP) serves eligible, enrolled members in the Maricopa GSA and has contracted with AHCCCS since 2000. At the time of this review, the Contractor had approximately 8,200 ALTCS members. For MCP's CYE 2007 OFR and at the request of the Contractor, AHCCCS conducted a joint Acute and ALTCS EPD OFR. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed the staff at work.

Findings

Figure 6-4 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-4—Categorized Levels of Compliance With Technical Standards *for* MCP[6-5]

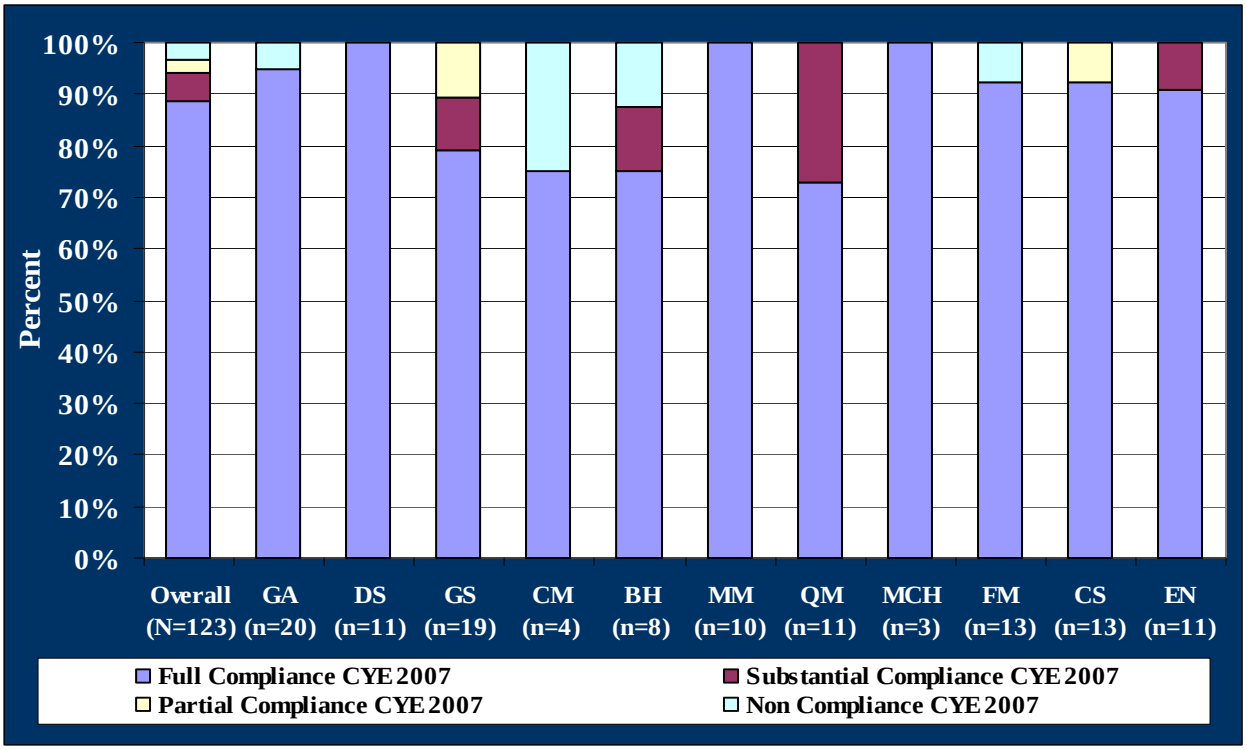


Figure 6-4 shows that MCP was in full compliance for 89 percent of the 123 reviewed standards (left-most bar) with generally consistent performance across the various categories of reviewed standards. This pattern resulted in generally higher compliance scores compared to other ALTCS EPD Contractors. Every standard within the Delivery Systems, Medical Management, and

[6-5] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

Maternal/Child Health categories was assessed to be in full compliance. Additionally, more than 90 percent of the standards within the General Administration, Financial Management, Claims Systems, and Encounters categories were assessed in full compliance.

Proportional to the number of standards within each category, the standards within the Quality Management category presented the largest opportunity for improvement, with only 73 percent of the reviewed standards in full compliance. This category was followed by Authorization and Denial/Grievance Systems, Case Management, and Behavioral Health, where 79 percent, 75 percent, and 75 percent of the reviewed standards were assessed in full compliance, respectively.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Authorization and Denial/Grievance Systems and Medical Management categories for MCP. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-4 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-4—Corrective Action Plans Per Category for MCP

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	1	6%	20	5%
Delivery Systems	0	0%	11	0%
Authorization & Denial/Grievance Systems	5	31%	19	26%
Case Management	1	6%	4	25%
Behavioral Health	2	13%	8	25%
Medical Management	1	6%	10	10%
Quality Management	3	19%	11	27%
Maternal/Child Health	0	0%	3	0%
Financial Management	1	6%	13	8%
Claims System	1	6%	13	8%
Encounters	1	6%	11	9%
Overall	**16**	**100%**	**123**	**13%**

Table 6-4 illustrates that almost one-third (5 out of 16 CAPs) of the required CAPs for MCP were within the Authorization and Denial/Grievance Systems category. These CAPs represented 26 percent of the standards in this category. Additionally, the Case Management, Behavioral Health, and Quality Management categories each required CAPs for at least 25 percent of the reviewed standards within each category (25 percent, 25 percent, and 27 percent, respectively). Notably, two categories did not require any CAPs (Delivery Systems and Maternal/Child Health), and six categories required only one CAP each (General Administration, Case Management, Medical Management, Financial Management, Claims Systems, and Encounters). Overall, the review for

MCP resulted in the lowest percentage of required CAPs among the ALTCS EPD Contractors (13 percent) as well as the lowest number of CAPs (16).

Strengths

All of the reviewed standards with the Delivery Systems, Medical Management, and Maternal/Child Health categories were assessed by AHCCCS as in full compliance with AHCCCS's technical standards. These areas were identified as a recognized strength for MCP. Additional strengths were also identified for the General Administration, Financial Management, Claims Systems, and Encounters categories, totaling just four CAPs (25 percent of all 16 CAPs) across 46 percent of all reviewed standards (57 out of 123 standards).

Opportunities for Improvement and Recommendations

In the final report generated from MCP's operational and financial review, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories—i.e., documentation of communication with members and providers and enhanced monitoring of MCP's processes and procedures. For example, AHCCCS recommended that MCP revise current policies to more clearly define the role of the chief medical officer (Quality Management and Maternal/Child Health) and to reflect required notification standards (Authorization and Denial/Grievance Systems, Behavioral Health, Case Management, and Claims Systems). These recommendations indicated the need to develop a systemwide approach to effective policymaking that focuses on drafting documents that are in alignment with AHCCCS requirements and that are written in commonly understood language. Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas will not only ensure MCP's improved compliance with AHCCCS standards, but lead to more efficient operations.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Authorization and Denial/Grievance Systems, Behavioral Health, and Quality Management.

- **Authorization and Denial/Grievance Systems**: Nearly one-third of the reviewed standards in this category (5 out of 16 standards) required a CAP in CYE 2007. Of these standards, four of the five required CAPs were within the first five standards. These standards specify the Contractor's required timing and interactions for prior authorizations and extended stays as well as process notification and documentation. This finding suggests an opportunity to improve an aspect of care that is central to member health and satisfaction. Prior authorizations and extended-stay authorizations should be grounded in clear and concise policies, processes, and procedures. Additionally, relevant materials should be made available in commonly understood language and formats. In most cases, minor modifications to existing documents and processes would enable MCP to move into full compliance with AHCCCS standards. To address these deficiencies, MCP should convene an internal work group to cross-reference current policies and procedures with AHCCCS's requirements. When discrepancies or the need for clarification are noted, MCP should take steps to reconcile documents and bring them into alignment with AHCCCS standards.

- **Behavioral Health**: The required CAPs within the Behavioral Health category involved aspects of care coordination. Specifically, one CAP was related to the Contractor's processes for coordinating behavioral health services with members' PCPs and other involved agencies and parties. The other CAP was related to the completion of routine well-child EPSDT developmental/behavioral health screenings for children. To address these CAPs, it is recommended that the Contractor evaluate the use of electronic health/medical records within its provider network. Electronic record systems not only provide accurate information on members' care, but also provide an important mechanism for coordinating care since implementation of these systems enables the sharing of vital member information across providers and case managers. Additionally, this type of shared information system would be able to facilitate and document the appropriate transfer of information and referral of members in a manner that would resolve the present CAPs. Moreover, when combined with reminder notifications, electronic health/medical record systems often result in more timely treatment. Electronic health/medical records may also help to reduce documentation errors related to the well-child EPSDT developmental/behavioral health screenings. Although MCP currently has a process in place to document and track this health screening, its current procedures do not include quality checks to ensure that the completed screenings are documented. An electronic health/medical record system could be designed to remind physician staff to document all applicable health screenings when a well-child visit is being performed. Also, since the provided service is being entered electronically, it is automatically tracked and stored, making monitoring providers more effective and efficient.
- **Quality Management**: The required CAPs for this category focused on member protection and included standards related to oversight and accountability for quality functions such as peer review, tracking and trending member abuse complaints and resolutions, and protecting basic member rights. Each of these areas represent an opportunity for improvement and are related to all three of the critical dimensions of care (quality, access, and timeliness). It is recommended that the Contractor conduct an internal audit of its policies and procedures and update those materials that are currently misaligned with AHCCCS's required standards. By cross-referencing MCP-specific policies with AHCCCS's technical standards, MCP can ensure its policies include all required language and content and are in compliance. Additionally, MCP should consider conducting an annual comparison between its policies and AHCCCS requirements to ensure that policies and procedures continue to remain in full compliance. It is also recommended that MCP review the structure of its Quality Management Committee to ensure appropriate documentation of committee actions regarding interventions developed and implemented as a result of member complaint/abuse issues.

Summary

The results for MCP showed strengths in the Delivery Systems, Medical Management, and Maternal/Child Health categories. Strengths were also identified in the General Administration, Financial Management, Claims Systems, and Encounters categories, with more that 90 percent of the standards in each category in full compliance with AHCCCS technical standards. However, these successes were somewhat tempered by the opportunities for improvement noted within the Authorization and Denial Grievance Systems, Behavioral Health, and Quality Management categories. Overall, MCP had a low number and percentage of CAPs and exhibited a high percentage of standards in full compliance compared to other ALTCS EPD Contractors.

Pima Health Systems

Pima Health Systems (PHS) serves eligible, enrolled members in Pima and Santa Cruz counties and has contracted with AHCCCS since October 1, 1988. At the time of this review, the Contractor had approximately 3,900 members. For PHS's CYE 2007 OFR and at the request of the Contractor, AHCCCS conducted a joint Acute and ALTCS EPD OFR. During the OFR the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed PHS's staff at work.

Findings

Figure 6-5 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-5—Categorized Levels of Compliance With Technical Standards *for* PHS[6-6]

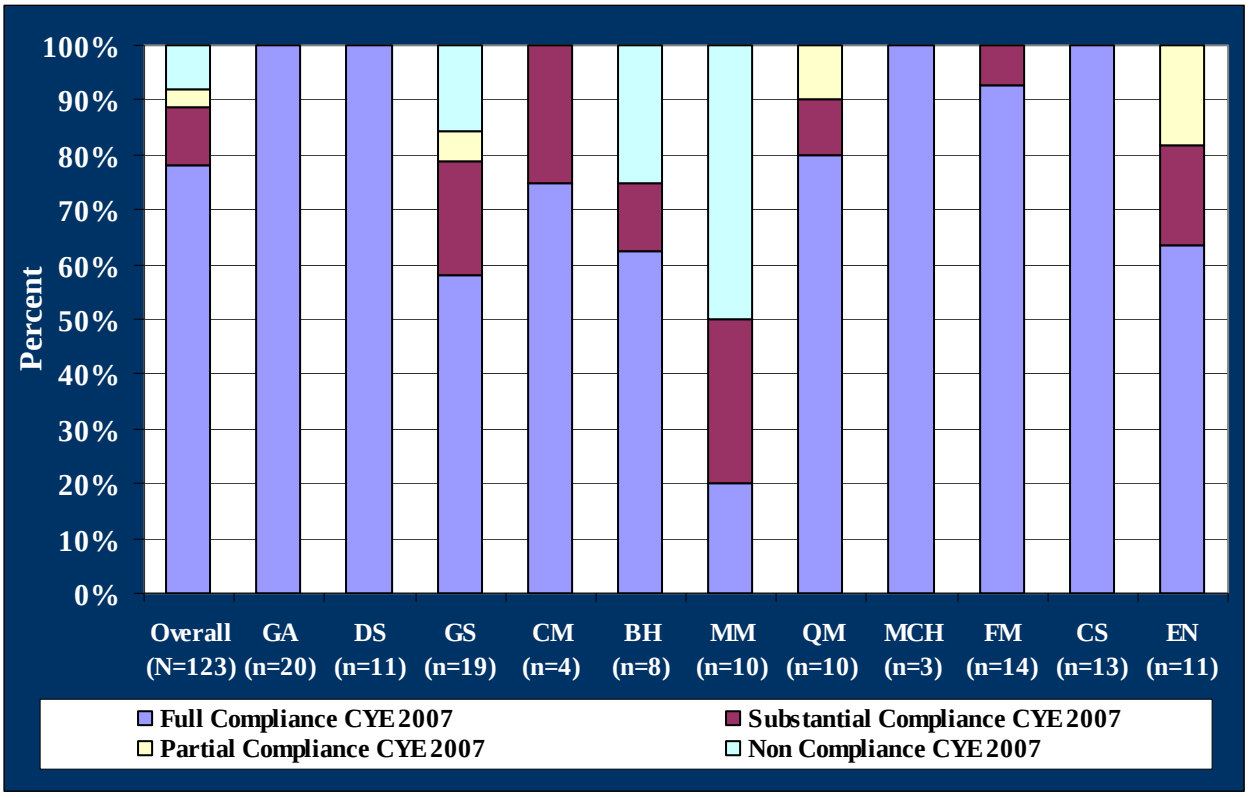


Figure 6-5 shows PHS in full compliance for 78 percent of the 123 reviewed standards (left-most bar) and considerable variation in performance across the categories of reviewed standards. The Contractor's strongest performance was for standards associated with the General Administration,

[6-6] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

Delivery Systems, Maternal/Child Health, and Claims Systems categories; all of the standards in these categories were assessed in full compliance. Moreover, the number of standards in these categories represented 38 percent of the total number of reviewed standards. Additionally, more than 90 percent of the standards within the Financial Management category were assessed as fully compliant.

Proportional to the number of standards within each category, the standards within the Medical Management category presented the greatest opportunity for improvement, with only 20 percent of the reviewed standards in full compliance. Other categories in which less than two-thirds of the reviewed standards were in full compliance included the Authorization and Denial/Grievance Systems, Behavioral Health, and Encounters categories (58 percent, 63 percent, and 64 percent, respectively). The results from these three categories also suggest important opportunities for improvement.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-5 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-5—Corrective Action Plans By Category for PHS

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	0	0%	20	0%
Delivery Systems	0	0%	11	0%
Authorization & Denial/Grievance Systems	8	30%	19	42%
Case Management	1	4%	4	25%
Behavioral Health	3	11%	8	38%
Medical Management	8	30%	10	80%
Quality Management	2	7%	10	20%
Maternal/Child Health	0	0%	3	0%
Financial Management	1	4%	14	7%
Claims System	0	0%	13	0%
Encounters	4	15%	11	36%
Overall	**27**	**100%**	**123**	**22%**

Table 6-5 shows that more than half (16 out of 27) of the required CAPs for PHS were evenly divided between the Authorization and Denial/Grievance Systems and Medical Management categories. Each of these categories represented 30 percent of the total number of CAPs required for PHS. Additionally, the Case Management, Behavioral Health, and Encounters categories each required CAPs for at least 25 percent of their reviewed standards. Notably, four categories did not require any CAPs (General Administration, Delivery Systems, Maternal/Child Health, and Claims System), and two categories required only one CAP each (Case Management and Financial

Management). Overall, slightly less than one-quarter (22 percent) of the reviewed standards for PHS in CYE 2007 required a CAP.

Strengths

All of the reviewed standards within the General Administration, Delivery Systems, Maternal/Child Health, and Claims Systems categories were assessed by AHCCCS as being in full compliance with the State's technical standards. These areas were a recognized strength for PHS. Additional strengths were also noted in PHS's performance in the Financial Management category as only one CAP was required out of the 14 reviewed standards.

Opportunities for Improvement and Recommendations

In the final report generated from PHS's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories, including the incorporation of required language in documents and enhanced monitoring of PHS's members and providers. For example, AHCCCS recommended that PHS revise its current policies and notification letters to include required elements such as correct dates, titles, and timelines in authorization notices and process letters (Authorization and Denial/Grievance Systems) as well as enhance existing emergency services policies and interrater reliability methodology (Medical Management). These recommendations indicate the need to develop a systemwide approach to effective policymaking that focuses on drafting documents that are in alignment with AHCCCS requirements and that are written in commonly understood language. AHCCCS also recommended that PHS work to improve monitoring of its authorization, denial, and grievance systems (Authorization and Denial/Grievance Systems); coordination of care (Behavioral Health); member utilization and disease management outcomes (Medical Management); and encounter data submission (Encounters). Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas, coupled with appropriate oversight and monitoring, will not only ensure PHS's improved compliance with AHCCCS's standards, but also lead to more efficient operations.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Authorization and Denial/Grievance Systems, Behavioral Health, Medical Management, and Encounters.

- **Authorization and Denial/Grievance Systems**: More than 40 percent of the reviewed standards in this category (8 out of 19 standards) required a CAP in CYE 2007. Of these standards, seven of the eight required CAPs were within the first seven standards. These standards relate to the Contractor's required timing and interactions for prior authorizations, continued-stays, member-specific information involving member rights, authorization decisions, and accuracy of several Contractor notices. These findings outline an important opportunity to improve an aspect of care that is central to member health and member/provider satisfaction. Prior authorizations and extended-stay authorizations should be grounded in clear and concise policies, processes, and procedures. Additionally, relevant materials should be made available in commonly understood language and formats. In most cases, minor modifications to existing documents and processes would enable PHS to move into full compliance with AHCCCS

standards. To address these deficiencies, PHS should convene an internal work group to cross-reference current policies and procedures with AHCCCS's requirements. When discrepancies or the need for clarification are identified, PHS should take corrective actions to revise the documents and bring them into alignment with AHCCCS standards. Additionally, PHS should review its current notification flow process related to authorization and denial/grievance systems, and identify where monitoring can be implemented to ensure all timeliness standards are met. Finally, current documentation standards should be reviewed, updated, and augmented as appropriate to ensure denial decisions are clearly supported in case file records. The development of an organizationwide culture of accurate and timely documentation is an important and effective strategy for implementing change.

- **Behavioral Health**: The required CAPs within the Behavioral Health category involved aspects of care coordination. Specifically, one CAP was related to the Contractor's processes for coordinating behavioral health services with members' PCPs and other involved agencies and parties while another CAP was related to the completion of routine well-child EPSDT developmental/behavioral health screenings for children. The third CAP was related to the requirement that case managers and providers be offered training on identifying and screening for members' behavioral health needs. To address these CAPs, it is recommended that the Contractor evaluate the use of electronic health/medical records within its provider network. Electronic records systems not only provide accurate information on members' care, but also provide an important mechanism for coordinating care since implementation of these systems enables the sharing of vital member information across providers and case managers. Additionally, this type of shared information system would be able to facilitate and document the appropriate transfer of information and referral of members in a manner that would assist in resolving the present CAPs. Moreover, when combined with reminder notifications, electronic health/medical record systems often result in more timely treatment. Electronic health/medical records may also help to reduce documentation errors related to the well-child EPSDT developmental/behavioral health screenings. Although PHS currently has a process in place to document and track the developmental/behavioral health screenings, its current procedures were unclear as to how performance was being monitored. With an electronic health/medical record, provider audits and reporting of compliance with this standard would be readily available making the monitoring of providers more effective and efficient. It is also recommended that PHS design and implement a comprehensive training program for case managers and providers with regard to identifying and screening for members' behavioral health needs. The training program should involve an initial training and periodic updates to ensure the retention of knowledge regarding current requirements, policies, and procedures. Finally, PHS should also evaluate the utility of alternative training forums such as Webinars.
- **Medical Management**: With 80 percent of the reviewed standards (8 out of 10) requiring a CAP, the entire category of Medical Management was assessed as an opportunity for improvement for PHS. Specific opportunities for improvement included implementing comprehensive monitoring programs for reviewing member utilization, intervention management activities, and member profiles; increasing scientific rigor in evaluating the interrater reliability and disease management outcomes; improving the quality of documentation of the Medical Management Committee meetings; and revising PHS policies and procedures to provide enhanced, and clear discussions of, mandatory contract requirements. To address these issues, it is recommended that PHS form an interdepartmental work group to evaluate the current structure of its Medical Management program. In addition to developing an aggressive

schedule for resolving system-related barriers to utilization reporting, the work group should identify ways to incorporate scientific rigor into its medical management activities, including the enhancement of current interrater reliability programs to ensure evaluation tools are comprehensive and capable of discerning the ability of nurses to make clinical decisions consistently and accurately. Additionally, industry standards for measuring disease management outcomes should be incorporated into ongoing monitoring programs. Implementing these monitoring and reporting strategies will not improve PHS' compliance with AHCCCS standards, but will assist PHS in delivering effective care to its members. It is also recommended that a work group review PHS's medical management policies and procedures. Specifically, each policy should be crosswalked to the associated AHCCCS standard to ensure all mandatory language and processes are clearly and concisely documented. In many cases, PHS would benefit from simply enhancing current policies by making them more comprehensive and descriptive of the procedures to be followed. Finally, PHS should consider modifying the Medical Management Committee structure and accountabilities to facilitate complete documentation of activities and decisions made by this group. This could include development of a standardized form for tracking and facilitating meeting discussions.

- **Encounters**: The processing of encounters represents an important opportunity for improvement for PHS. More than one-third (36 percent, or 4 out of 11) of the reviewed standards required a CAP in CYE 2007. AHCCCS's review of the these standards found several standards in less than full compliance with the requirement for encounter data measures to be within one standard deviation from the mean (i.e., ratio of approved encounters, ratio of total pended encounters, and ratio of newly pended [less than 30 days] encounters). This review also found opportunities for improvement in the completeness, accuracy, and timeliness of data based on reviewing a sample of paid claims. Based on these findings, it is recommended that PHS conduct a root-cause analysis to identify whether system-based issues are contributing to the quality of encounter data being submitted to AHCCCS. Although some of the issues were identified with the accuracy and completeness of PHS's encounter data, a thorough review of its encounter systems is necessary to ensure future compliance with AHCCCS submission standards. PHS's review should include a review of internal data cleaning and management processes and the adjudication process. The review should also evaluate encounter data completeness and claim type in order to isolate any potential pattern or anomalies. Additionally, it is recommended that PHS evaluate its current procedures for monitoring submission of encounter data. Active and ongoing review of current submissions should detect adverse submission patterns, allowing PHS to correct errors early.

Summary

The results from the CYE 2007 review illustrated that the General Administration, Delivery Systems, Maternal/Child Health, and Claims Systems categories were recognized strengths for PHS. All of the reviewed standards in each of these categories were in full compliance. Nonetheless, these successes were tempered by the considerable opportunities for improvement within the Authorization and Denial/Grievance Systems, Behavioral Health, Medical Management, and Encounter categories.

Pinal/Gila Long Term Care

Pinal/Gila Long Term Care (P/GLTC) serves eligible, enrolled members in Pinal and Gila counties and has contracted with AHCCCS since October 1, 1990. At the time of this review, the Contractor had approximately 1,246 members. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed P/GLTC's staff at work.

Findings

Figure 6-6 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-6—Categorized Levels of Compliance With Technical Standards *for* P/GLTC[6-7]

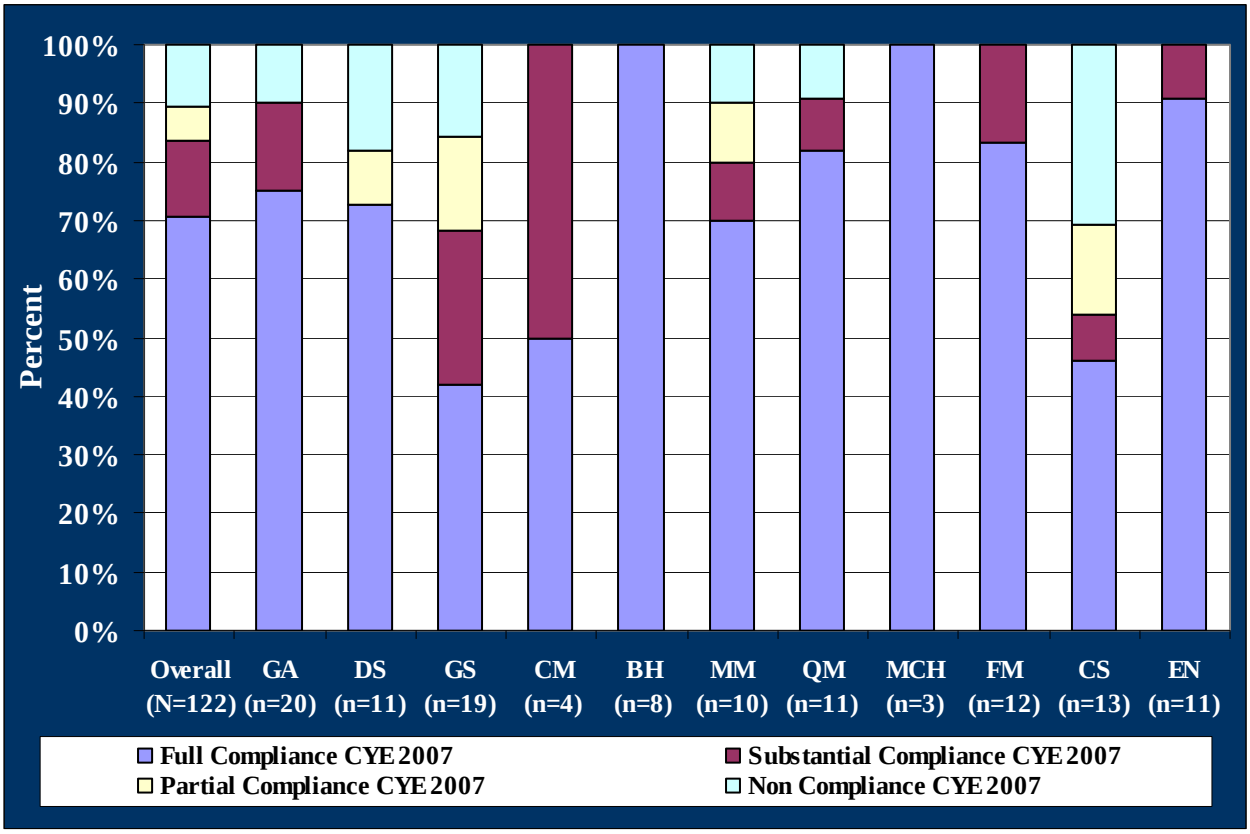


Figure 6-6 shows P/GLTC in full compliance for 70 percent of the 122 reviewed standards (left-most bar) and considerable variation in its performance across the different categories of reviewed standards. The Contractor's strongest performance was for the standards associated with the

[6-7] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

Behavioral Health and the Maternal/Child Health categories; all standards in these categories were assessed as in full compliance. Additionally, more than 90 percent of the standards within the Encounters category were assessed as in full compliance. However, the standards in these three categories represented only 18 percent of the total number of reviewed standards.

Proportional to the number of standards within each category, the Authorization and Denial/Grievance Systems category shows the greatest opportunity for improvement with only 42 percent of the reviewed standards in full compliance. Similarly, the results for the Claims System and Case Management categories also showed that approximately half of the reviewed standards in these categories were assessed as in full compliance (46 percent and 50 percent, respectively). The results for these three categories suggest important opportunities for improvement.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Authorization and Denial/Grievance Systems and Delivery Systems categories for P/GLTC. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-6 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-6—Corrective Action Plans By Category for P/GLTC

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	5	13%	20	25%
Delivery Systems	4	11%	11	36%
Authorization & Denial/Grievance Systems	12	32%	19	63%
Case Management	2	5%	4	50%
Behavioral Health	0	0%	8	0%
Medical Management	3	8%	10	30%
Quality Management	2	5%	11	18%
Maternal/Child Health	0	0%	3	0%
Financial Management	2	5%	12	17%
Claims System	7	18%	13	54%
Encounters	1	3%	11	9%
Overall	**38**	**100%**	**122**	**31%**

Table 6-6 shows that almost one-third (12 out of 38) of the required CAPs for P/GLTC were within the Authorization and Denial/Grievance Systems category. These CAPs represented 63 percent of the standards reviewed in these categories. Additionally, the General Administration, Delivery Systems, Case Management, Medical Management, and Claims System categories each required CAPs for at least 25 percent of their reviewed standards. Notably, two categories did not require any CAPs (Behavioral Health and Maternal/Child Health), and one category received only one CAP

(Encounters). Overall, approximately one in every three of the standards reviewed for P/GLTC resulted in a CAP during CYE 2007.

Strengths

The results for P/GLTC showed strengths in the Behavioral Health and the Maternal/Child Health categories. Further, the Encounters category showed full compliance scores in excess of 90 percent.

Opportunities for Improvement and Recommendations

In the final report generated from P/GLTC's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: including required language in policies/procedures and other documents, and enhancing monitoring of P/GLTC's members and providers. For example, AHCCCS recommended that P/GLTC revise current policies and materials to include required elements such as correct dates, titles, and timelines in authorization notices and process letters (Authorization and Denial/Grievance Systems and Medical Management) as well as developing new policies that were missing during AHCCCS's OFR (Claims Systems, Medical Management, and Delivery Systems). AHCCCS also recommended that information in member and provider handbooks be updated with clearer references to the toll-free language line for interpreter services (General Administration), and that P/GLTC not restrict advocacy by health care providers (Delivery Systems). These recommendations indicate the need to develop a systemwide approach to effective policymaking that focuses on drafting documents that are in alignment with AHCCCS requirements and that are written in commonly understood language. Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas will not only ensure P/GLTC's improved compliance with AHCCCS's standards, but will also lead to more efficient operations. AHCCCS also recommended that P/GLTC work to improve its compliance monitoring program (General Administration); its authorization, denial, and grievance systems (Authorization and Denial/Grievance Systems); HCBS services (Quality Management), and encounter data submission (Encounters). Again, establishing a comprehensive strategy of monitoring performance in all operational areas should improve P/GLTC's compliance with AHCCCS standards, improve overall operational performance results, and positively impact member care and services.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: General Administration, Delivery Systems, Authorization and Denial/Grievance Systems, Delivery Systems, Case Management, Medical Management, and Claims Systems.

- **General Administration**: One-quarter (5 out of 20 standards) of the reviewed standards required a CAP in CYE 2007, representing comparatively large opportunities for improvement. A review of P/GLTC's General Administration CAPs highlights two underlying themes: cultural competency and corporate compliance. These educational and operational opportunities for P/GLTC's improvement activities included the enhancement of informational and instructional materials provided to members, outlining culturally competent materials and services; strengthening its current compliance oversight, monitoring and reporting activities; and general improvement in the timeliness of all contract deliverables. Based on the review findings,

it is recommended that P/GLTC should use existing committees to review its corporate strategy for ensuring the cultural competency of its organization. This review should include feedback from members in order to identify areas where P/GLTC is deficient in identifying and providing cultural and linguistic services. At a minimum, these efforts should include the enhancement of existing member materials, such as the member handbook. Additionally, efforts should be taken to augment the current operations of the Corporate Compliance Committee to include an annual review of P/GLTC's compliance program.

- **Delivery Systems**: Overall, more than one-third (36 percent, or 4 of 11) of the reviewed standards required a CAP in CYE 2007. The required CAPs were related to the development of a policy to notify members of PCP termination and policies addressing providers' rights and responsibilities. Although P/GLTC has several policies and procedures in place to address the omissions noted in AHCCCS's OFR findings, the policies and procedures were incomplete. It is recommended that P/GLTC use established quality committees to review and update existing policies and procedures and ensure that they are aligned with AHCCCS contract language and requirements. The Contractor should also implement an annual review of its policies and procedures to ensure that they continue to be in compliance with AHCCCS standards.
- **Authorization and Denial/Grievance Systems**: Of the 19 standards reviewed in this category, 63 percent, or 12, of the standards required a CAP in CYE 2007. These standards related to the Contractor's required timing and interactions for prior authorizations, continued-stays, member-specific information involving member rights with regard to decisions made on authorizations, and the accuracy of several Contractor notices. These findings outline an important opportunity to improve an aspect of care that is central to member health and member/provider satisfaction. Authorization policies, procedures, and communication should be clear and concise and written in commonly understood language and formats. In most cases, modifications to existing documents and processes would enable P/GLTC to move toward full compliance with most of AHCCCS's standards. To address these deficiencies, P/GLTC should convene an internal work group to cross-reference current policies and procedures with AHCCCS's requirements. When discrepancies or the need for clarification are noted, P/GLTC should take steps to reconcile documents and bring them into alignment with AHCCCS standards. Additionally, this work group should conduct a root-cause analysis to identify current work flow problems that impact the timeliness of notifications for members and providers. Once the reasons for current deficiencies are identified, steps should be taken to develop concrete processes to ensure the appropriate and timely required member and provider notifications. Further, P/GLTC should establish a review process and accountabilities to ensure that its policies and procedures are reviewed on an annual basis and revised when needed to remain consistent with AHCCCS requirements.
- **Case Management**: Overall, 50 percent of the reviewed standards in the Case Management category (two of the four standards) required a CAP. Although there were only four standards associated with this category (two standards were not applicable), the results suggest considerable opportunity for improvement. In general, these standards require the Contractor to monitor its case management program for policy compliance and to monitor case management caseloads. This type of monitoring should be integrated into the corporate quality improvement program. For this reason, it is recommended that P/GLTC review all of its monitoring activities, not just for the Case Management category, to ensure that quality, timeliness, and access measures are either improving or at least not declining. Additionally, it is recommended that

these monitoring activities be incorporated into the responsibilities of existing committees in order to capitalize on current organizational strengths and systems.

- **Medical Management**: Of the 10 standards reviewed in this category, 30 percent, or 3, of the standards required a CAP in CYE 2007. However, the three required CAPs within the Medical Management category were somewhat divergent in nature. One CAP required that the Contractor develop policies and procedures for an interrater reliability program that proactively evaluates the accuracy of staff performance regarding the application of standardized criteria in making clinical determinations. The second CAP required that the Contractor have an effective concurrent review process that includes a component for reviewing the medical necessity of inpatient stays. The third CAP was to ensure that the Contractor has adopted and implemented a policy for the evaluation of new technologies that complies with AHCCCS standards. Based on AHCCCS's findings, it is recommended that an internal work group be developed to review P/GLTC's medical management policies and procedures. Specifically, each policy should be crosswalked to its associated AHCCCS standard to ensure all mandatory language and processes are clearly and concisely documented. Regarding the interrater reliability program, members from multiple departments should be recruited to help facilitate the development of a comprehensive monitoring program rooted in sound scientific methodology.
- **Claims System**: Overall, a little more than half (54 percent, or 7 out of 13 standards)) of the standards reviewed in the Claims System category required a CAP. These required CAPs were due in large part to noted deficiencies in P/GLTC's written policies and procedures. Specifically, the standards that required CAPs were related to the identification of erroneously paid claims; notification to AHCCCS when annual recoupment of monies exceeded $50,000 dollars for individual providers, written policies and procedures for adjudicating claims for prior-period coverage and recouping monies later than 12 months prior, and a mechanism to collect and monitor claim disputes, appeals, and resolution across departments. AHCCCS also noted the need to formalize the training processes for provider services representatives. As noted in the recommendations for other categories, P/GLTC should convene an interdepartmental work group to develop policies and procedures in areas where processes do not currently exist. This work group should evaluate current deficiencies and design a comprehensive strategy for enhancing monitoring and management of claim systems processes. Additionally, P/GLTC should evaluate its current training and professional development programs to ensure the processes are formalized and ongoing, especially for the provider services representatives. In many cases, the documentation of existing processes will enable P/GLTC to move toward full compliance with many of AHCCCS's standards. Finally, through the use of an interdepartmental work group, P/GLTC should work on developing cross-department business flows for coordinating and sharing common information (i.e., claim disputes, appeals, and resolutions). Increased awareness and communication between departments should help address several of the CYE 2007 required CAPs.

Summary

The results from the CYE 2007 review illustrated that the Behavioral Health, Maternal/Child Health, and Encounters categories were recognized strengths for P/GLTC. At least 90 percent of the reviewed standards in each of these categories were in full compliance. Nonetheless, these successes were somewhat tempered by the noted opportunities for improvement within the General Administration, Delivery Systems, Authorization and Denial/Grievance Systems, Case

Management, Medical Management, and Claims System categories. At least 25 percent of the standards reviewed in each of these categories required a CAP.

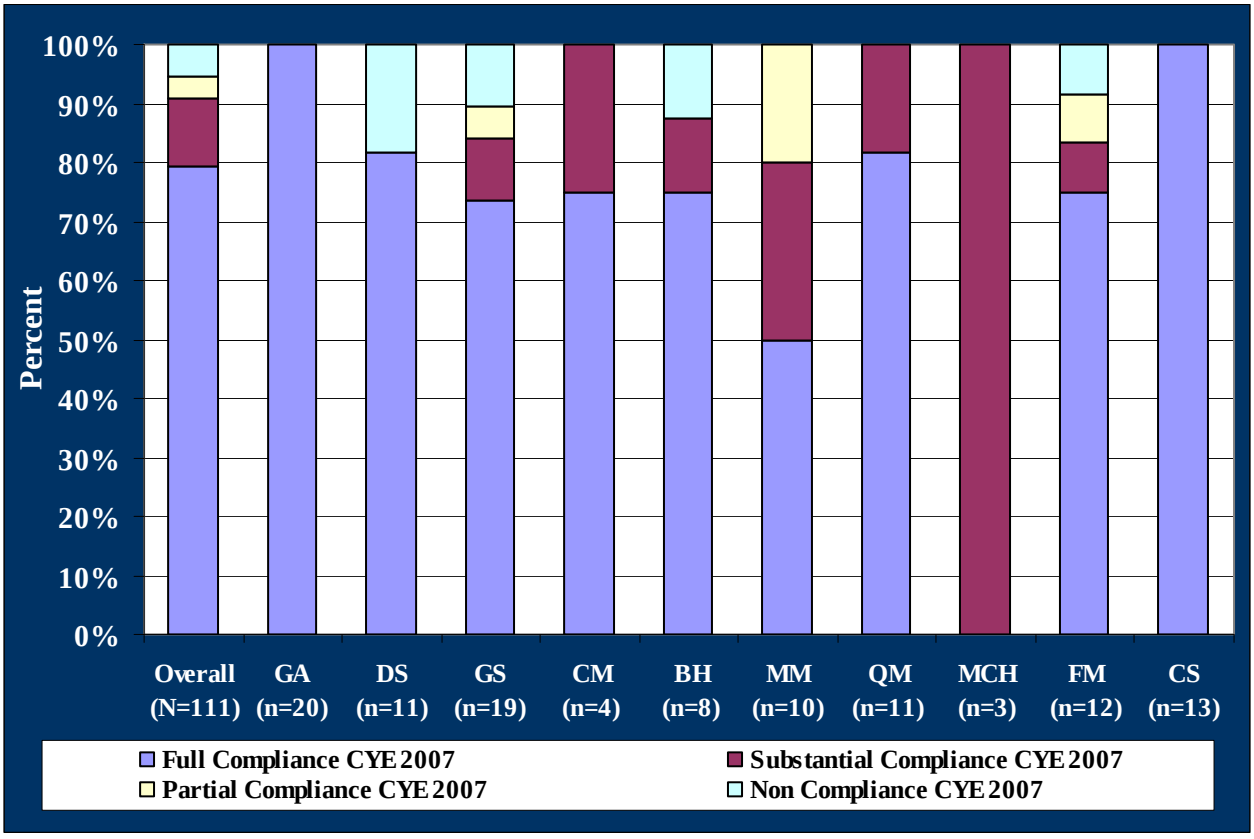
SCAN Long Term Care

SCAN Long Term Care (SCAN) serves eligible, enrolled members in Maricopa County and has contracted with AHCCCS since October 1, 2006. At the time of this review, the Contractor had approximately 647 members. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed SCAN's staff at work.

Findings

Figure 6-7 presents the overall compliance results (i.e., far-left bar) and the results for each of 10 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-7—Categorized Levels of Compliance With Technical Standards *for* SCAN[6-8]



[6-8] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, and CS=Claims System.

Figure 6-7 shows SCAN in full compliance for 79 percent of the 111 reviewed standards (left-most bar), with moderate variation in performance across the categories of reviewed standards. The Contractor's strongest performance was for the standards associated with the General Administration and the Claims System categories. AHCCCS scored all reviewed standards within both of these categories as fully compliant. No other categories had more than 85 percent of the reviewed standards assessed in full compliance.

Proportional to the number of standards within each category, the Maternal/Child Health category showed the greatest opportunity for improvement with none of the reviewed standards in this category in full compliance with AHCCCS's technical standards. Additionally, only 50 percent of the reviewed standards within the Medical Management category were assessed in full compliance. Both of these results suggest important opportunities for improvement for SCAN.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-7 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-7—Corrective Action Plans By Category for SCAN

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	0	0%	20	0%
Delivery Systems	2	9%	11	18%
Authorization & Denial/Grievance Systems	5	22%	19	26%
Case Management	1	4%	4	25%
Behavioral Health	2	9%	8	25%
Medical Management	5	22%	10	50%
Quality Management	2	9%	11	18%
Maternal/Child Health	3	13%	3	100%
Financial Management	3	13%	12	25%
Claims System	0	0%	13	0%
Overall	**23**	**100%**	**111**	**21%**

Table 6-7 shows that the CAPs for SCAN were broadly distributed across the 10 reviewed categories. Overall, six categories showed that at least 25 percent of the reviewed standards in a given category required a CAP in CYE 2007: Authorization and Denial/Grievance Systems, Case Management, Behavioral Health, Medical Management, Maternal/Child Health, and Financial Management). Of these six categories, three indicate extensive opportunities for improvement for SCAN—i.e., Authorization and Denial/Grievance Systems, Medical Management, and Maternal/Child Health. However, two categories did not have any required CAPs (General Administration and Claims System), and one category required only one CAP (Case Management), although this category has just four standards. Overall, slightly more than one-fifth (21 percent) of the compliance standards reviewed for SCAN in CYE 2007 resulted in a required CAP.

Strengths

All of the reviewed standards within the General Administration and Claims System categories were assessed by AHCCCS as being in full compliance with the State's technical standards. These areas were identified as a recognized strength for SCAN. No other category had at least 85 percent of its reviewed standards in full compliance.

Opportunities for Improvement and Recommendations

In the final report generated from SCAN's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories. These themes included the incorporation and clearer presentation of required language in provider contracts, member/provider handbooks, and written notifications, and enhanced monitoring of SCAN's members and providers. For example, AHCCCS recommended that SCAN revise current policies and materials to include required elements such as nondiscrimination clauses for providers serving high-risk members and informing providers of their right to advocate on a member's behalf (Delivery Systems), members' rights regarding the grievance/appeal process (Authorization and Denial/Grievance Systems), and the enhancement of existing policies to explain in greater detail the internal processes surrounding oversight activities and the use of audit/reporting results, review of new technologies, and the use of emergency services (Case Management and Medical Management). These recommendations indicate the need for SCAN to develop a systemwide approach to effective policymaking that focuses on drafting documents that are in alignment with AHCCCS requirements and that are written in commonly understood language. Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas will not only ensure SCAN's improved compliance with AHCCCS's standards, but will also lead to more efficient operations. AHCCCS also recommended that SCAN work to improve its monitoring of provider compliance with appointment standards, general accessibility of behavioral health services (Behavioral Health), oversight of pharmacy benefits (Authorization and Denial/Grievance Systems), member utilization, interrater reliability performance of staff, SCAN's disease management program (Medical Management), ongoing monitoring of SCAN's EPSDT participation rates, and provider use of the EPSDT form (Maternal/Child Health). Establishing a comprehensive strategy of monitoring performance in all operational areas will not only move SCAN toward compliance with AHCCCS standards, but also strengthen SCAN's operational performance and associated outcomes/results. It is highly recommended that SCAN evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Authorization and Denial/Grievance Systems, Medical Management, and Maternal/Child Health.

- **Authorization and Denial/Grievance Systems**: Of the 19 standards reviewed in this category, 26 percent, or 5, of the standards required a CAP in CYE 2007. These standards were related to effective communication to members regarding the denial and grievance systems and associated time frames through notices and handbooks, SCAN's internal processes for calculating the time

frame for filing appeals, development of an oversight process to monitor SCAN's pharmacy benefit manager's compliance with the timeliness of prior authorizations, and not using an independent medical professional when reviewing appeals. These findings outline an important opportunity to improve an aspect of care that is central to member health and member/provider satisfaction. Authorization policies, procedures, and communication should be clear and concise and written in commonly understood language and formats. In most cases, modifications to existing documents and processes would enable SCAN to move toward full compliance with most of AHCCCS's standards. To address these deficiencies, SCAN should cross-reference current policies and procedures with AHCCCS's requirements to identify areas where discrepancies exist or clarification is needed. SCAN should then take steps to modify its policies, procedures, and handbooks to bring them into alignment with AHCCCS standards. SCAN should collaborate with other ALTCS EPD Contractors to identify best practices for presenting information clearly to members. Further, SCAN should establish a review process in which policies and procedures are reviewed on an annual basis. Finally, SCAN should conduct an internal review of its oversight procedures, including its calculation of appeal time frames and pharmacy benefit manager compliance with prior-authorization standards. Once the reasons for current deficiencies are identified, steps should be taken to develop concrete processes to ensure the appropriate monitoring of vendors and members' rights.

- **Medical Management**: With half of the reviewed standards requiring a CAP in CYE 2007, the Medical Management category was identified as an overall opportunity for improvement. Specific opportunities for improvement included implementation of a comprehensive monitoring program for member utilization and associated interventions, expansion of the current interrater reliability policies and procedures, clarification of policies related to emergency room authorizations and payments and new technologies, and the development of a disease management program, including effective monitoring and oversight. Each of these CAPs highlighted areas where SCAN had only partially implemented processes that comply with AHCCCS's technical standards. For example, while SCAN had policies and procedures in place to monitor and address provider utilization concerns, it did not have a strategy for monitoring member utilization. It is recommended that SCAN form an internal work group to evaluate current monitoring programs and identify efficient mechanisms for expanding current monitoring efforts to include member utilization and interventions. This or another work group should also discuss, design, and implement a comprehensive disease management program that includes outcomes measurement and quality improvement activities. It is also recommended that SCAN cross-reference policies related to new technology, interrater reliability, and emergency room authorizations to AHCCCS contract requirement in order to ensure all AHCCCS-required language is included.
- **Maternal/Child Health**: Although there were only three standards reviewed in the Maternal/Child Health category, SCAN was required to complete a CAP for all three. For this reason, the entire category is considered an opportunity for improvement. In general, SCAN had an EPSDT program in place, but it was not fully monitoring the program in alignment with AHCCCS standards. Specifically, SCAN was not reviewing EPSDT participation rates, the use of EPSDT forms, or age-appropriate screenings. To address these deficiencies, it is recommended that SCAN establish a comprehensive strategy and policy for monitoring EPSDT-related services. Drawing on existing internal committees, SCAN should develop monitoring tools and reports that provide timely data on members' utilization of key preventive services and provider performance. This information should then be incorporated into quality improvement

activities established to increase the preventive services and quality of care children receive. Since all three of the reviewed standards in the category were assessed in substantial compliance, minor modifications to the operations of current committees and the establishment of monitoring procedures should be effective in resolving these CAPs.

Summary

The results from the CYE 2007 review illustrated that the General Administration and Claims System categories were recognized strengths for SCAN. All of the reviewed standards in each of these categories were in full compliance. Nonetheless, these successes were somewhat tempered by the noted opportunities for improvement within the Authorization and Denial/Grievance Systems, Medical Management, and Maternal/Child Health categories. Overall, SCAN's performance indicated consistent opportunities for improvement across 8 of the 10 categories reviewed.

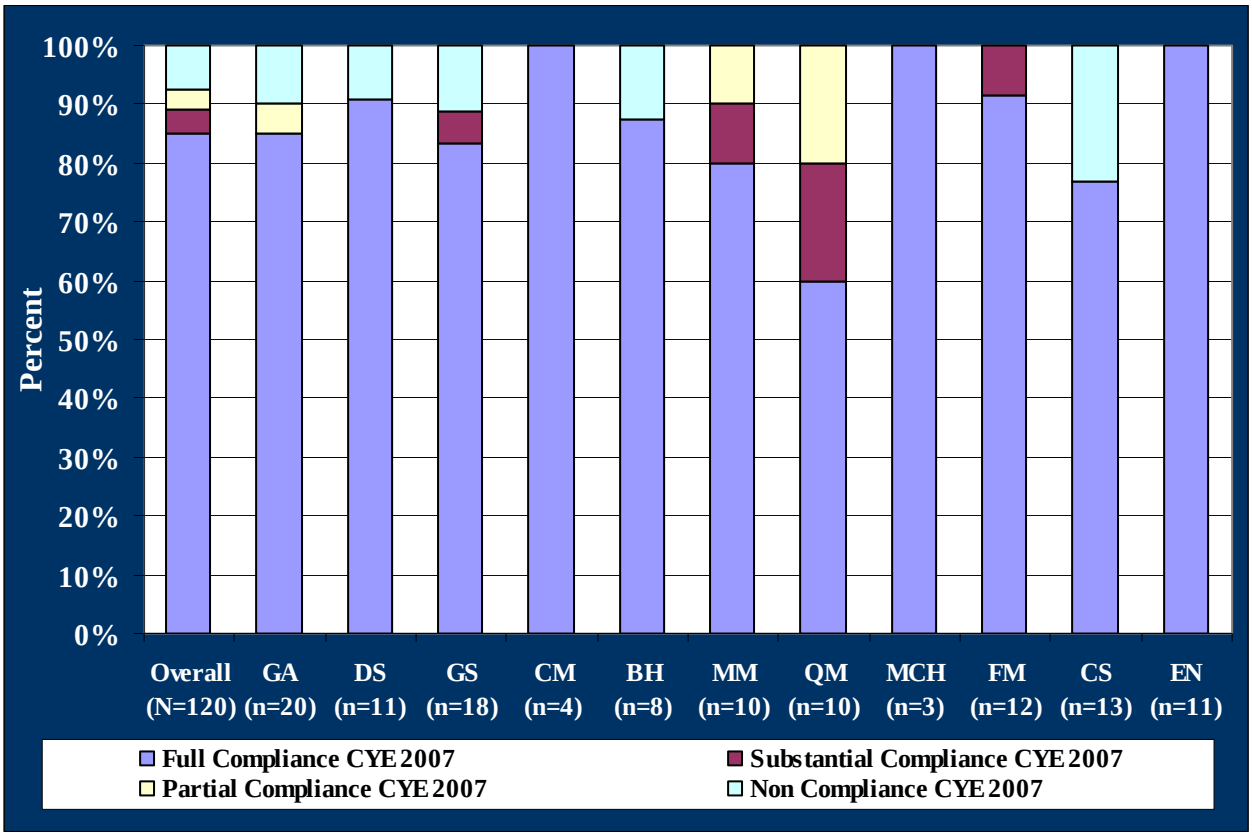
Yavapai County Long Term Care

Yavapai County Long Term Care (YCLTC) serves eligible, enrolled members in Yavapai County and has contracted with AHCCCS since October 1, 1993. At the time of this review, the Contractor had approximately 930 members. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed YCLTC's staff at work.

Findings

Figure 6-8 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-8—Categorized Levels of Compliance With Technical Standards *for* YCLTC[6-9]



[6-9] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

Figure 6-8 shows YCLTC in full compliance for 85 percent of the 120 reviewed standards (left-most bar), with relatively consistent performance across the categories of reviewed standards. YCLTC's performance represents the second-highest performance among the EPD Contractors. The Contractor's strongest performance was for standards within the Case Management, Maternal/Child Health, and Encounters categories; all standards were assessed as being in full compliance. Additionally, all other categories except Quality Management and Claims System were assessed in full compliance for at least 80 percent of the reviewed standards.

Proportional to the number of standards within each category, the standards within the Quality Management category represented the largest opportunity for improvement with only 60 percent of the reviewed standards in full compliance. This category was followed by Claims System, for which 77 percent of the reviewed standards were in full compliance.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-8 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed in CYE 2007.

Table 6-8—Corrective Action Plans By Category for YCLTC

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	3	17%	20	15%
Delivery Systems	1	6%	11	9%
Authorization & Denial/Grievance Systems	3	17%	18	17%
Case Management	0	0%	4	0%
Behavioral Health	1	6%	8	13%
Medical Management	2	11%	10	20%
Quality Management	4	22%	10	40%
Maternal/Child Health	0	0%	3	0%
Financial Management	1	6%	12	8%
Claims System	3	17%	13	23%
Encounters	0	0%	11	0%
Overall	**18**	**100%**	**120**	**15%**

Table 6-8 shows that more than one-fifth (22 percent, or 4 out of 18) of the required CAPs for YCLTC were within the Quality Management category. No other category required more than three CAPs. The CAPs for YCLTC, therefore, were distributed broadly across the various review categories. Overall, YCLTC's CYE 2007 review resulted in the second-lowest percentage of CAPs for any of the ALTCS EPD Contractors (15 percent) as well as the second-lowest number of required CAPs (18).

Strengths

All of the reviewed standards within the Case Management, Maternal/Child Health, and Encounters categories were assessed as in full compliance with AHCCCS's technical standards. These areas were identified as recognized strengths for YCLTC. Additional strengths were identified within the Delivery Systems, Behavioral Health, and Financial Management categories, for which only three CAPs were required (17 percent of all CAPs) across just over one-quarter (26 percent) of all reviewed standards (31 out of 120 standards).

Opportunities for Improvement and Recommendations

In the final report generated from YCLTC's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: effective communication with members and providers, and enhanced monitoring of YCLTC's members and providers. For example, AHCCCS recommended that YCLTC develop policies and procedures for informing members of the availability of culturally competent materials and programs, and for informing members of their rights regarding authorizations and the grievance process (General Administration and Authorization and Denial/Grievance Systems). AHCCCS also recommended that YCLTC develop policies and procedures for informing providers of their right to advocate on a member's behalf (Delivery Systems). These recommendations highlight the need for YCLTC to evaluate its current policymaking processes and ensure that all policies address all AHCCCS-relevant requirements. Additionally, YCLTC should ensure that all documents are written in commonly understood language for both members and providers. Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas will not only improve YCLTC's compliance with AHCCCS's standards, but also lead to more efficient operations. AHCCCS also recommended that YCLTC work to improve its monitoring of internal activities such as YCLTC's compliance program (General Administration), interrater reliability performance (Medical Management), employee/provider eligibility to participate in Medicaid (General Administration), and member referrals (Behavioral Health). These recommendations highlight the importance of establishing a comprehensive strategy for monitoring performance across all operational areas. It is recommended that YCLTC evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Quality Management and Claims System.

- **Quality Management**: Compared with the other reviewed categories, the Quality Management category required the largest number of CAPs (4 out of 10 standards) in CYE 2007. Representing 40 percent of the standards within this category, the entire area is an opportunity for improvement for YCLTC. The CAPs were related to issues with oversight and the peer-review processes, improving quality performance results, verifying the credentials of organizational providers, and appropriate oversight and annual monitoring of delegated credentialing functions. It is recommended that the Contractor conduct an internal audit of its policies and procedures and update those materials that are currently misaligned with

AHCCCS's required standards. By cross-referencing YCLTC-specific policies with AHCCCS's technical standards, YCLTC can ensure that its policies include all required language and that the content complies with AHCCCS requirements. Additionally, YCLTC should consider conducting an annual comparison between its policies and AHCCCS requirements to ensure that policies and procedures continue to remain in full compliance. YCLTC's internal audit processes should also identify deficiencies in its current credentialing program and take corrective action to incorporate ongoing review of organizational providers and delegates. Additionally, steps should be taken to increase the scope of work addressed by YCLTC's Quality Management/Performance Improvement Committee to ensure it is being used to effectively administer the credentialing program.

- **Claims System**: Overall, 23 percent (3 out of 13) of the reviewed standards required a CAP in CYE 2007. These standards addressed YCLTC's claims dashboard and policies addressing the recoupment of funds from providers. In general, it is recommended that YCLTC develop an annual process to crosswalk its policies to AHCCCS technical standards. Once discrepancies are noted, steps should be taken to address deficiencies by drafting new policies or enhancing current ones. Additionally, YCLTC should identify an appropriate committee and assign responsibility and accountability for ensuring the accuracy and relevance of all policies and procedures.

Summary

YCLTC exhibited the second-strongest performance of the ALTCS EPD Contractors with 85 percent of its reviewed standards in full compliance during CYE 2007. The results for YCLTC showed organizational strengths in the Case Management, Maternal/Child Health, and Encounters categories. All reviewed standards in these categories were assessed as in full compliance. Additionally, all but two of the remaining categories (i.e., Quality Management and Claims Systems) showed relatively high performance results with at least 80 percent of the reviewed standards in full compliance.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

DES/DDD serves eligible, enrolled members in all 15 counties in Arizona and has contracted with AHCCCS since 1989. At the time of the review, the Contractor had approximately 19,200 members. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed DES/DDD's staff at work.

Findings

Figure 6-9 presents the overall compliance results (i.e., far-left bar) and the results for each of 11 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-9—Categorized Levels of Compliance With Technical Standards *for* DES/DDD[6-10]

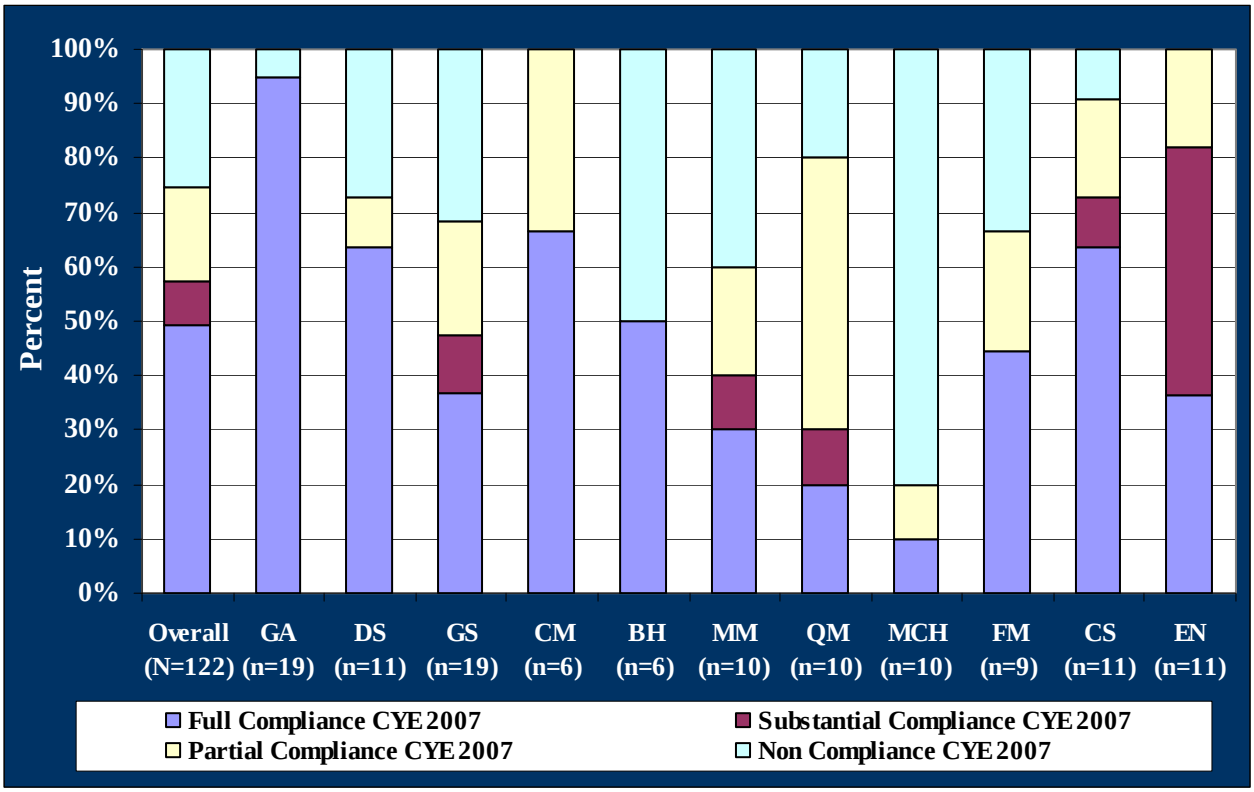


Figure 6-9 shows DES/DDD in full compliance for almost half (49 percent) of the 122 reviewed standards (left-most bar), with considerable variation in its performance across the different categories. The Contractor's strongest performance was for standards associated with the General

[6-10] The compliance categories are abbreviated as follows: GA=General Administration, DS=Delivery Systems, GS=Authorization and Denial/Grievance Systems, CM=Case Management, BH=Behavioral Health, MM=Medical Management, QM=Quality Management, MCH=Maternal/Child Health, FM=Financial Management, CS=Claims System, and EN=Encounters.

Administration category. Within this category, 95 percent of the reviewed standards were assessed in full compliance with the AHCCCS technical standards. Of the 19 reviewed standards associated with this category, only 1 standard (timely submission of contract deliverables) required a CAP in CYE 2007.

Proportional to the number of standards within each category, the Maternal/Child Health category presented the largest opportunity for improvement. Of the 11 categories reviewed, the Maternal/Child Health category displayed the lowest percentage of standards in full compliance (10 percent) and the highest percentage of standards assessed as in noncompliance (80 percent). Other categories for which less than 60 percent of the reviewed standards were in full compliance included the Authorization and Denial/Grievance Systems, Behavioral Health, Medical Management, Quality Management, Financial Management, and Encounters categories.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Authorization and Denial/Grievance Systems and Claims System categories for DES/DDD. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-9 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed in CYE 2007.

Table 6-9—Corrective Action Plans By Category for DES/DDD

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	1	2%	19	5%
Delivery Systems	4	6%	11	36%
Authorization & Denial/Grievance Systems	13	20%	19	68%
Case Management	2	3%	6	33%
Behavioral Health	3	5%	6	50%
Medical Management	7	11%	10	70%
Quality Management	8	12%	10	80%
Maternal/Child Health	9	14%	10	90%
Financial Management	5	8%	9	56%
Claims System	6	9%	11	55%
Encounters	7	11%	11	64%
Overall	**65**	**100%**	**122**	**53%**

Table 6-9 shows that 20 percent (13 out of 65) of the required CAPs for DES/DDD were within the Authorization and Denial/Grievance Systems category. Although this finding is somewhat influenced by the relatively large number of standards within the category, the Authorization and Denial/Grievance category represented a clustering of opportunities for improvement for the Contractor. Additionally, the Maternal/Child Health and Quality Management categories show

considerable opportunity with 90 percent and 80 percent, respectively, of the reviewed standards requiring a CAP. The Behavioral Health, Medical Management, Financial Management, Claims System, and Encounters categories all required a CAP for at least 45 percent of the standards reviewed in each category. Overall, more than half (53 percent) of the reviewed standards in CYE 2007 required DES/DDD to complete a CAP; moreover, at least one CAP was required within each of the 11 categories.

Table 6-10 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of reviewed standards within each category can be compared from year to year.

Table 6-10—Two-Year CAP Overview for DES/DDD

Category (# of Standards)	CYE 2006		CYE 2007	
	Number of CAPs	% of Category Standards	Number of CAPs	% of Category Standards
General Administration	3	43%	1	5%
Delivery Systems	0	0%	4	36%
Authorization & Denial/Grievance Systems	1	20%	13	68%
Case Management	3	75%	2	33%
Behavioral Health	4	50%	3	50%
Medical Management	9	100%	7	70%
Quality Management	4	80%	8	80%
Maternal/Child Health	6	75%	9	90%
Overall CAPs	**30**	**63%**	**47**	**52%**
Total Number of Standards Reviewed	**42**		**91**	

In general, Table 6-10 indicates overall improvement in performance based on the overall reduction in the percentage of required CAPs from CYE 2006 (63 percent) to CYE 2007 (52 percent). However, when evaluated by individual category, the findings suggested relatively flat performance with the number of CAPs decreasing for three categories (38 percent), remaining constant for two categories (25 percent), and increasing for three categories (38 percent). While DES/DDD made some progress with respect to the overall percentage of reviewed compliance standards requiring a CAP, the finding that more than half of the standards reviewed in CYE 2007 required a CAP highlights systemwide opportunities for improvement.

Strengths

DES/DDD's performance for the General Administration category was a recognized strength during the CYE 2007 review since 1 of the 19 reviewed standards (5 percent) required a CAP (i.e., the timely submission of contract deliverables). This finding indicates that 95 percent of the standards reviewed within this category were assessed in full compliance with AHCCCS technical standards.

Opportunities for Improvement and Recommendations

In the final report generated from DES/DDD's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. With every category requiring at least one CAP, DES/DDD has extensive opportunities for improvement overall. As outlined in AHCCCS's review, DES/DDD should: enhance member education and communication, identify members' behavioral health needs and coordinate appropriate services, ensure operational policies and procedures contain AHCCCS-mandated provisions, train staff on AHCCCS case management policies, enhance its oversight of communication to providers, and improve its organizational monitoring and operational and quality improvement activities, as well as its general reporting to AHCCCS. In general, HSAG's review supports these recommendations and includes the following additional recommendations.

Due to its continued failure to achieve acceptable compliance across nearly all categories under review, it is recommended that DES/DDD conduct a comprehensive review of its operations and systems in order to understand the systemwide barriers that consistently impeded the sufficiency of its performance. In the CYE 2006 Annual Report, it was recommended that DES/DDD appoint and convene a Contractor-wide committee to review and analyze probable root causes that contribute to its poor performance. In light of its continuing unsatisfactory performance, it is recommended that DES/DDD designate such a committee as a standing committee. Moreover, this cross-departmental committee should be required to report its activities and progress to senior management, including the medical director. At a minimum, the committee should be empowered to both review and analyze systems issues as well implement identified changes. At a minimum, this proposed committee should focus on:

- Reorganizing Contractor functions and organizational structures to facilitate improved effectiveness of the Contractor's health care operations and to strengthen performance accountabilities.
- Enhancing written policies and procedures to ensure they not only address AHCCCS requirements, but are also written in clear, descriptive, and commonly understood language.
- Developing rigorous monitoring procedures and tools capable of rapid-cycle evaluation of performance by staff, providers, and contractors as well as member utilization of services.
- Implementing targeted, strategic improvement actions and interventions selected as a result of the organizationwide comprehensive assessment, specific performance results revealed through the enhanced and rigorous monitoring activities, and any other areas the Contractor identifies as critical to improving its performance.

Summary

While DES/DDD made some progress with respect to its overall performance for the reviewed compliance standards, more than half of the standards reviewed in CYE 2007 required a CAP. DES/DDD did not demonstrate substantively strong improvement from CYE 2006. These results suggest that the Contractor was not successful in identifying the critical root causes of prior systemwide performance deficits and/or implementing effective systemwide interventions and/or monitoring activities to generate improved performance.

DES/DDD is encouraged to launch an aggressive, systemwide, and comprehensive assessment of its performance in complying with AHCCCS contractual requirements. This assessment should include the critical actions it must take to improve operations and prioritizing those standards where performance is most in need of improvement. DES/DDD may also want to consider whether it would be beneficial to engage external consultants or, at a minimum, ALTCS EPD Contractors with stronger performance, to assist in its root-cause analysis and selection of improvement interventions.

Comparative Results for ALTCS EPD Contractors

The following section presents a comparative analysis of the performance results from AHCCCS's OFR for the eight ALTCS EPD Contractors. Findings are provided on the proportion of each Contractor's compliance standards assessed in full compliance, substantial compliance, partial compliance, and noncompliance. A comparison of the percentage of reviewed compliance standards requiring a CAP is also presented by Contractor.

Findings

Figure 6-10 shows the overall percentage of each Contractor's reviewed standards AHCCCS found to be in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars. The left-most bar in the figure shows the proportions for compliance categories across the eight EPD Contractors.

Figure 6-10—Percentages in Full Compliance With Technical Standards *for* ALTCS EPD Contractors[6-11]

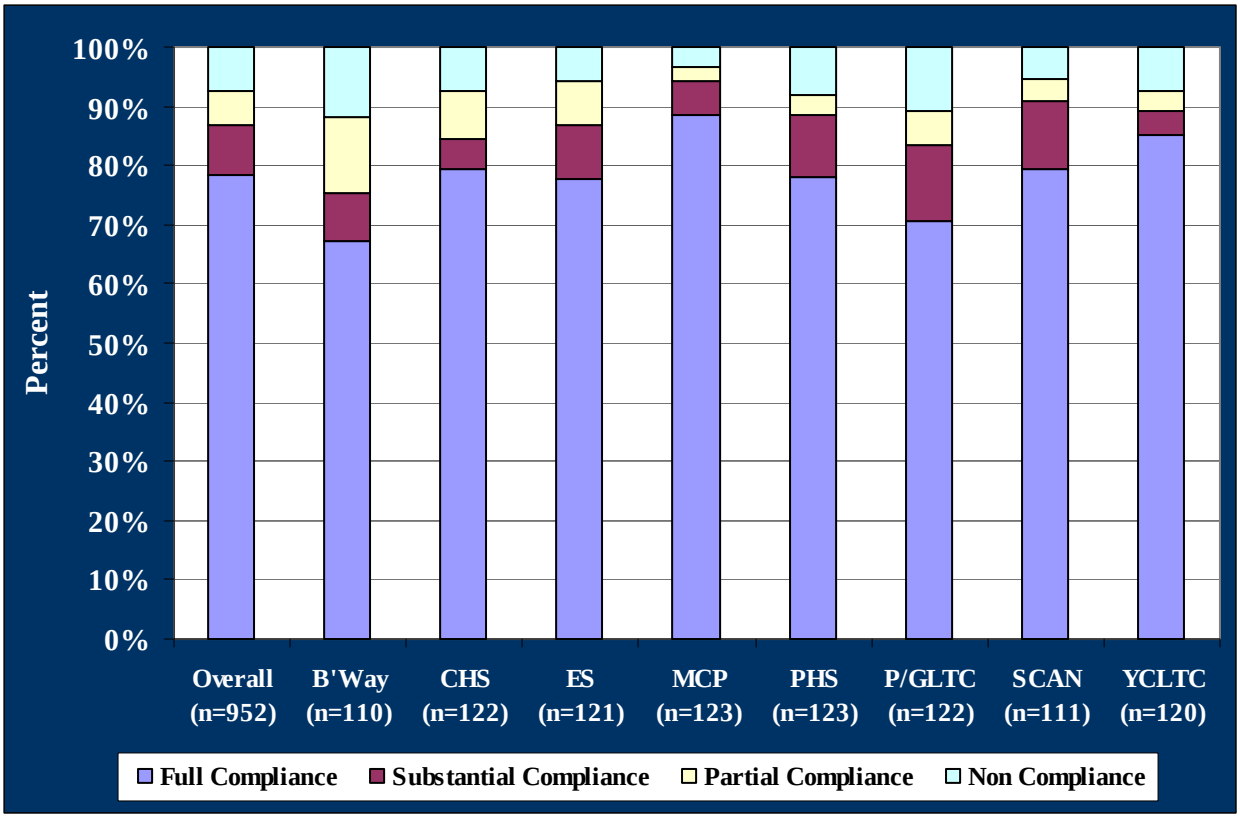


Figure 6-10 shows that 78 percent of all reviewed standards were in full compliance across the eight ALTCS EPD Contractors. Two Contractors showed results that were substantively higher than the

[6-11] The Contractors' names were abbreviated as follows: B'way=Bridgeway Health Solutions, CHS=Cochise Health Systems, ES=Evercare Select, MCP=Mercy Care Plan, PHS=Pima Health Systems, P/GLTC=Pinal/Gila Long Term Care, SCAN=SCAN Long Term Care, and YCLTC=Yavapai County Long Term Care.

overall Contractors' average across all reviewed standards: MCP (89 percent) and YCLTC (85 percent). Conversely, two of the other Contractors showed results that were substantively lower than the overall average (i.e., B'Way and P/GLTC). Of these two Contractors, B'Way exhibited slightly lower performance as evidenced by a somewhat higher percentage of standards assessed in partial and noncompliance (25 percent) compared to P/GLTC (16 percent). Figure 6-10 also shows that CHS, ES, PHS, and SCAN performed similarly regarding the number of standards assessed in full compliance (80 percent, 78 percent, 78 percent, and 78 percent, respectively). Among these Contractors, SCAN and PHS exhibited the largest proportion of standards in substantial compliance (12 percent and 11 percent, respectively) followed by ES (9 percent) and CHS (5 percent).

In general, when AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. However, AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred five times across the ALTCS EPD Contractors. For this reason, Figure 6-11 presents the percentage of required CAPs overall and separately for each ALTCS EPD Contractor.

Figure 6-11—Percentages of Compliance Standards With Required CAPs *for* ALTCS EPD Contractors[6-12]

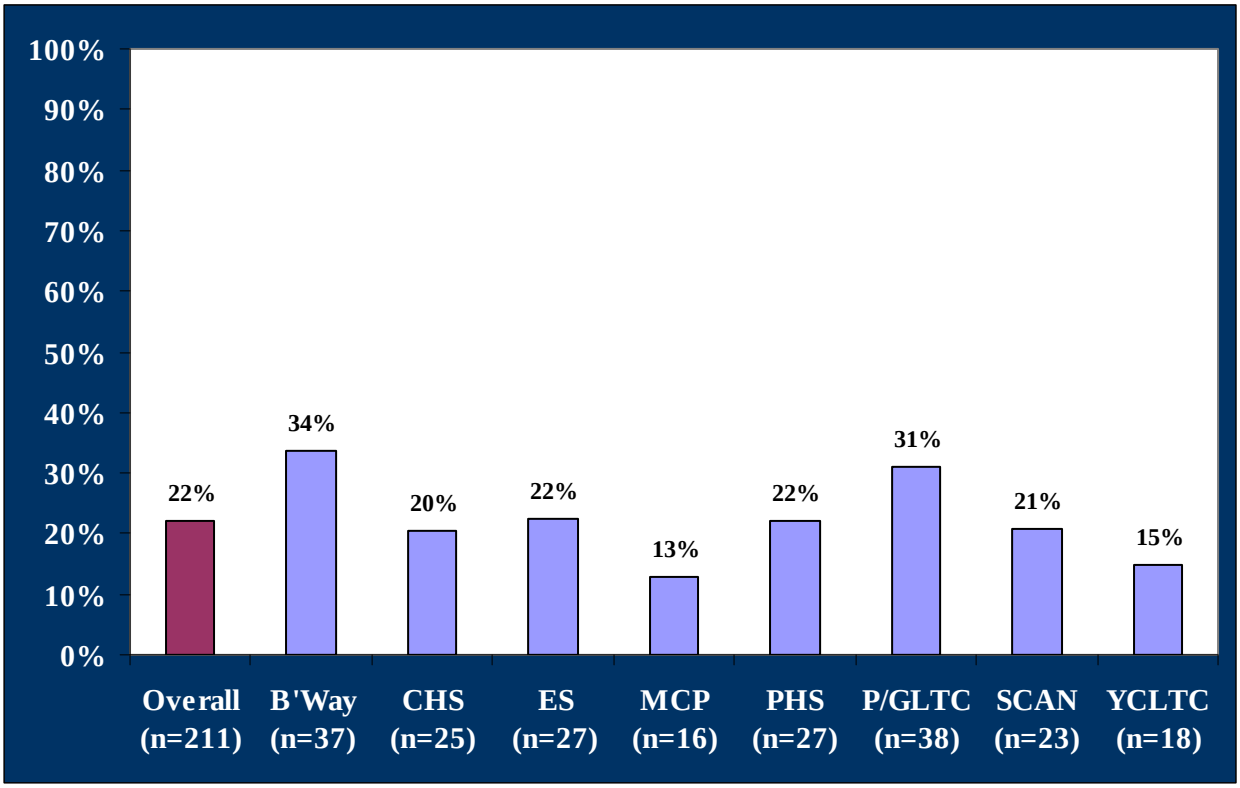


Figure 6-11 shows that on average, 22 percent of the reviewed compliance standards across all Contractors required a CAP in CYE 2007. MCP required the smallest percentage of CAPs (13

[6-12] B'way=Bridgeway Health Solutions, CHS=Cochise Health Systems, ES=Evercare Select, MCP=Mercy Care Plan, PHS=Pima Health Systems, P/GLTC=Pinal/Gila Long Term Care, SCAN=SCAN Long Term Care, and YCLTC=Yavapai County Long Term Care.

percent) followed by YCLTC (15 percent). Conversely, the largest percentages of CAPs were required for B'Way and P/GLTC (34 percent and 31 percent, respectively). Overall, systemwide opportunities for improvement were noted across ALTCS EPD Contractors since more than one in every five reviewed compliance standards required a CAP.

A comparison of the CAPs across compliance categories highlights areas for quality improvement activities across ALTCS EPD Contractors as a group. Table 6-11 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed in CYE 2007 for all ALTCS EPD Contractors.

Table 6-11—Corrective Action Plans By Category for ALTCS EPD Contractors

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
General Administration	20	9%	160	13%
Delivery Systems	12	6%	88	14%
Authorization & Denial/Grievance Systems	51	24%	151	34%
Case Management	7	3%	32	22%
Behavioral Health	17	8%	64	27%
Medical Management	34	16%	80	43%
Quality Management	25	12%	85	29%
Maternal/Child Health	4	2%	24	17%
Financial Management	15	7%	98	15%
Claims System	16	8%	104	15%
Encounters	10	5%	66	15%
Overall	**211**	**100%**	**952**	**22%**

Table 6-11 shows that for the Medical Management category, 43 percent (34 out of 80) of the reviewed standards required a CAP in CYE 2007. This finding strongly suggests statewide opportunities for improvement in this compliance category. Additionally, slightly more than one-third (34 percent) of the reviewed standards in the Authorization and Denial/Grievance Systems category required a CAP, while CAPs were required for between 20 to 30 percent of standards evaluated for the Case Management, Behavioral Health, and Quality Management categories. In general, these findings suggest widespread opportunities for improvement across the eight ALTCS EPD Contractors.

Strengths

The results presented in Figure 6-10 and Figure 6-11 illustrate considerably stronger performance for MCP and YCLTC. The results from AHCCCS's review suggest that these Contractors' performance and overall operations were substantively more compliant than those evaluated for other ALTCS EPD Contractors. However, even for the category with the fewest required CAPs (General Administration, with 20 CAPs), approximately one in every eight reviewed standards (13 percent) required a CAP. None of the compliance categories was recognized as a clear strength across all ALTCS EPD Contractors.

Opportunities for Improvement and Recommendations

For the highest-performing Contractor (MCP) with the greatest proportional compliance with the performance standards, approximately one in every seven compliance standards required a CAP. The proportion increased to more than one in every three compliance standards requiring a CAP for the lowest-performing Contractor. The range of results supports the recommendation for systemwide operational improvements across the Contractors. Improvement activities should focus on more effectively using existing quality and medical management committees focused on enhancing monitoring and oversight of Contractor performance, and implementing targeted improvement activities and interventions.

The reviewed standards within the Medical Management category show the greatest statewide opportunity for improvement, with 43 percent (34 out of 80 standards) of the reviewed standards requiring a CAP. This percentage is substantively higher than the percentage of CAPs required for any other category. Additionally, seven of the eight ALTCS EPD Contractors had a required CAP for the Medical Management standard: "The Contractor has implemented and monitors a comprehensive inter-rater reliability plan to ensure consistent application of criteria for clinical decision making." Except for MCP, which was fully compliant, this standard is a statewide opportunity for improvement for the ALTCS EPD Contractors.

In general, it is recommended that ALTCS EPD Contractors conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS mandated requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards. Additionally, Contractors should review all documents, including member, provider, and staff communications, and ensure that they are written in commonly understood language. Finally, ALTCS EPD Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to either develop new procedures and review mechanisms, or augment existing ones. In many cases, Contractors can apply lessons learned from improving performance for one category of standards and apply them to improving performance for other categories.

Summary

The ALTCS EPD Contractors cannot be assessed this year for improvement in their compliance with standards for the OFRs because AHCCCS did not conduct a comparable, extensive review for the eight EPD Contractors for CYE 2006. Instead, it conducted a follow-up review of the EPD Contractors' corrective action plans, which AHCCCS required as a result of findings from its extensive OFRs in CYE 2005. Nonetheless, the relatively large proportion of standards requiring a CAP suggests widespread continued opportunities for improvement for the ALTCS EPD Contractors. The results for the current review did indicate that MCP and YCLTC returned the highest compliance ratings of all ALTCS EPD Contractors, while B'Way and P/GLTC exhibited the largest number of opportunities for improvement.

In accordance with 42 CFR 438.240(b), AHCCCS contractually requires Contractors to have a QAPI program that includes measuring and submitting data to AHCCCS on their performance. Validating MCO and PIHP performance measures is one of the three BBA mandatory external quality review activities described at 42 CFR 438.358(b)(2). The requirement at 438.358(a) allows states, its agents that are not an MCO or PIHP, or an EQRO to conduct the mandatory activities. Performance results can be reported to the state by the MCOs/PIHPs (as required by the state) or the state can calculate the MCOs'/PIHPs' performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs—or calculated by the state—and validated annually.

As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the BBA mandatory activity of validating performance measures. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1-5), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its performance measure calculation and its data validation activities to prepare this 2006–2007 annual report.

Conducting the Review

AHCCCS calculated and reported Contractor-specific and statewide-aggregate performance for the following AHCCCS-selected measures for the EPD Contractors:

- Initiation of Home and Community-Based Services (HCBS)
- Comprehensive Diabetes Care (i.e., HbA1c Testing, LDL-C Screening, and Eye Exam)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Participation Rate

For DES/DDD, AHCCCS calculated and reported performance for the following AHCCCS-required measures:

- Children's Access to Primary Care Providers (12–24 months, 25 months–6 years, 7–11 years, and 12–19 years)
- Well-Child Visits (Third, Fourth, Fifth, and Sixth Years of Life)
- Adolescent Well-Care Visits
- Annual Dental Visits (Ages 4–21)
- EPSDT Participation

Using AHCCCS's results and statistical analysis of Contractors' performance rates, HSAG organized, aggregated, and analyzed the performance data. From its analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality and timeliness of, and access to, care and services Contractors provided to AHCCCS members.

Objectives for Conducting the Review

In its objectives to measure, report, compare, and continually improve Contractor performance AHCCCS conducted the following activities:

- Provided key information about AHCCCS-selected performance measures to each Contractor
- Used Contractor data AHCCCS collected to calculate the performance measure rates
- Performed encounter validation according to industry standards

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for seven of the nine ALTCS EPD and DES/DDD Contractors' performance with respect to each of the AHCCCS-selected measures. Two of the nine current Contractors (Bridgeway Health Solutions and SCAN Long Term Care) had not been AHCCCS contractors long enough for AHCCCS to have performance data available for them. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- Determine Contractor performance on each of the AHCCCS-selected measures.
- Compare Contractor performance to AHCCCS's MPS, goals, and long-range benchmarks for each measure.
- Provide data from analyzing the performance results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide across the Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide across Contractors.

Methodology for Conducting the Review

For the review period of CYE 2007, i.e., measurement year ending September 30, 2006, AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each of the State-selected measures and associated Contractor-reported data collected from member medical and/or case management records.
- Calculated, for each measure, Contractor-specific performance rates and statewide aggregate rates across all Contractors.
- Performed encounter validation according to industry standards.
- Reported Contractors' performance results by individual Contractor and in aggregate statewide.
- Compared Contractor performance rates with standards defined by AHCCCS's contract.
- Required Contractors to submit CAPs to AHCCCS for its review and approval when their performance did not meet AHCCCS's MPS for one or more measures.

Contractor CAPs had to include an evaluation of the effectiveness of Contractors' current interventions and, when necessary, their plans to revise or replace them. AHCCCS required Contractors to include updates on the status and effectiveness of the CAPs in their annual Quality

Management/Performance Improvement Plans and Evaluation, an AHCCCS-required contract deliverable.

AHCCCS calculates the Contractors' performance rates for AHCCCS-selected measures. To calculate the rates for the measures, AHCCCS used a combination of data:

- Administrative data collected from its automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS). AHCCCS selected sample members and services meeting numerator criteria from the Recipient and Encounter Subsystems of PMMIS.
- Data the Contractors collect from medical and/or case management records, and for which they provided supporting documentation.

The exception to AHCCCS having used this hybrid method to collect Contractor performance data was for the EPSDT Participation Rate measure. For this measure, AHCCCS collected only administrative data and followed a methodology CMS developed for the EPSDT Form 416 report that all state Medicaid agencies must annually submit to CMS.

AHCCCS used HEDIS specifications to calculate Contractor performance rates for the diabetes measures. AHCCCS used administrative data collected from its PMMIS system. AHCCCS selected members included in the denominator for each measure from the Recipient Subsystem of PMMIS. As a result, the numerators, and therefore the performance rates, are based on encounter data (records of services Contractors provided and the associated claims Contractors paid) in the PMMIS. The encounter data reported were based on Contractors' encounters for professional services, primarily physician clinic and office visits. AHCCCS conducts annual validation studies of encounters. Based on the most recent validation study applicable to the data for this report, AHCCCS determined that a high percentage of the encounters for professional services were both complete compared with the associated medical records and accurate compared with services documented in members' medical records. Because AHCCCS calculated performance rates based on Contractor-submitted encounters, AHCCCS noted that rates may have been negatively affected if Contractors did not complete and submit all encounters for services provided that were applicable and could have been included in the calculations for performance for a given measure.

Using the performance rates and statistical analysis AHCCCS calculated for each Contractor, HSAG organized, aggregated, and analyzed the data in order to draw conclusions about Contractor performance in providing accessible, timely, and quality care and services to AHCCCS members. AHCCCS analyzed contractor-specific and statewide-aggregate performance results for each measure to determine:

- If Contractor performance rates met or exceeded AHCCCS's MPS, goals, or long-range benchmarks.
- The direction of any change in rates from previous measurement periods and whether the change was statistically significant.
- If a CAP was required.

AHCCCS required Contractors to submit a CAP to improve their performance on a measure when their performance rates did not achieve the AHCCCS MPS

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide-aggregate performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented its recommendations to improve Contractor performance rates.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results across the Contractors. As noted above, two of AHCCCS's eight current ALTCS EPD Contractors (i.e., Bridgeway Health Solutions and SCAN Long Term Care) had not been AHCCCS Contractors long enough for AHCCCS to have data available for them.

Contractor-Specific Results

AHCCCS provided data on the CYE 2007 performance measure rates for six ALTCS EPD Contractors and for DES/DDD. The six ALTCS EPD Contractors include Cochise Health Systems (CHS), Evercare Select (ES), Mercy Care Plan (MCP), Pima Health System (PHS), Pinal/Gila Long Term Care (P/GLTC), and Yavapai County Long Term Care (YCLTC). The five measures reported in CYE 2007 were also reported in CYE 2006. The performance measures were:

- Initiation of HCBS
- HbA1c Testing
- Lipid Screening
- Retinal Exams
- EPSDT Participation

The individual results are presented next.

Cochise Health Systems

CHS serves eligible, enrolled members in Cochise, Graham, and Greenlee counties and has contracted with AHCCCS since 1993. At the time of this review, the Contractor had approximately 900 members.

Findings

Table 7-1 presents the performance measure rates for CHS. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 minimum performance standard, (MPS), goal, and long-range benchmark.

Table 7-1—Performance Measurement Review *for* CHS

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[B]	95.6%	97.7%	2.2%	p=1.00	84%	85%	98%
Diabetes Management—HbA1c Testing	79.4%	79.8%	0.5%	p=.945	75%	77%	88%
Diabetes Management—Lipid Screening	78.4%	81.9%	4.5%	p=.537	76%	78%	85%
Diabetes Management—Retinal Exams	68.0%	55.3%	-18.7%	p=.070	45%	47%	64%
EPSDT Participation	100%	85.7%	-14.3%	N/A[C]	50%	53%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05.

[B] HCBS=Home and Community-Based Services.

[C] A value of "N/A" indicates that statistical testing was not done due to the small sample size (i.e., n=7)

Using the AHCCCS CYE 2007 MPS, goals, and long-range benchmarks as frames of reference, CHS returned excellent single-year results for its performance measure rates. The rate for the Initiation of HCBS measure (97.7 percent) was within 0.3 percentage points of the AHCCCS long-range benchmark and exceeded both the CYE 2007 MPS and AHCCCS goal (84 percent and 85 percent, respectively). Additionally, all three measures of diabetes management (HbA1c Testing, Lipid Screening, and Retinal Exams) also showed rates (79.8 percent, 81.9 percent, and 55.3 percent, respectively) that were above the AHCCCS goals. The rate for Lipid Screening was above the AHCCCS goal, as well. However, the results showed statistically flat performance between CYE 2006 and CYE 2007 for the four measures with calculated *p* values. In comparing

performance between contract years, two measures warranted further review—i.e., Diabetes Management—Retinal Exams and EPSDT Participation.

For the Diabetes Management—Retinal Exams measure, the change in rates from 68.0 percent (CYE 2006) to 55.3 percent (CYE 2007) was not statistically significant ($p = .070$). However, since the result was close to the traditionally accepted maximum test value of $p \leq .05$, the finding suggests that CHS should consider implementing additional quality improvement efforts to limit the risk of a statistically significant drop in the future. While the current rate for retinal exams was still above the AHCCCS MPS (45 percent) and goal (47 percent), it was no longer above the AHCCCS Long-Range Benchmark of 64 percent.

The second measure warranting further examination is the EPSDT Participation rate, for which performance changed from 100 percent (CYE 2006) to 85.7 percent (CYE 2007). With only seven eligible members during the measurement period[7-1], the failure of one member to participate in EPSDT services resulted in the change in rates shown in Table 7-1. Nonetheless, the CYE 2007 EPSDT Participation rate of 85.7 percent was still above the AHCCCS long-range benchmark rate of 80 percent. No other change in performance measure rates approached statistical significance.

CAPs

CHS did not have any CAPs required for the performance measure review during either the current or previous contract period.

Strengths

The results for Initiation of HCBS (97.7 percent) clearly show this activity to be a strength for CHS. The Contractor's rate for this measure was 13.7 percentage points higher than the CYE 2007 MPS (84 percent). HCBS services were initiated for almost all eligible members. Although EPSDT Participation might also appear to be a strength by showing a rate that was 35.7 percentage points higher than the CYE 2007 MPS of 50 percent, the rate exhibited a relative change of 14.3 percentage points. Although this drop represented a single member not receiving EPSDT services, it prevented this measure from being considered a strength for CHS. Nonetheless, CHS's overall performance measure results, especially the demonstration of no required CAPs during the past two contract cycles, indicate strong CYE 2007 performance by the Contractor, as assessed against AHCCCS's CYE 2007 MPS, goals, and long-range benchmarks.

Opportunities for Improvement and Recommendations

As noted above, no CAPs were required for CHS's performance for the measures. Nonetheless, the rates for two measures (i.e., Diabetes Management—Retinal Exams and EPSDT Participation) appear to be declining, although the change was not statistically significant.

- Diabetes Management—Retinal Exams: The rate for CHS remained 10.3 percentage points above the CYE 2007 MPS of 45 percent despite the Contractor's rate falling 18.7 percent (12.7 percentage points). Even though the change in rates between CYE 2006 and CYE 2007 did not

[7-1] Due to the small sample size associated with the measure, statistical testing was not conducted. Also, statistical testing would not normally be conducted for rates at 0 or 100 percent.

reach statistical significance ($p \leq .05$), CHS's performance suggests a potential decline in performance.

Performing retinal eye exams addresses all three BBA-designated aspects of care and services (i.e., quality, timeliness, and access). From a quality perspective, failure to provide periodic diabetic eye exams is evidence of not appropriately following nationally accepted medical guidelines. From a timeliness perspective, performing periodic eye exams for diabetics has been shown to reduce the incidence of blindness through early detection of diabetic retinopathy for repair. From an access perspective, increasing rates for diabetic eye exams often includes enhanced member access to care and services by expanding the network of providers, working to extend providers' hours, providing member transportation, or a combination of the these or other strategies. As such, CHS should review its current interventions and work to identify strategies for improving the effectives of current outreach.

- **EPSDT Participation:** At the time of the review, CHS had only seven members who were eligible for inclusion in the EPSDT Participation measure. Of these seven members, six members received EPSDT services. With an eligible population of this size, CHS should consider individual member-based strategies for maintaining a 100 percent participation rate among its eligible members. Ultimately, however, the current rate for this measure was still above the AHCCCS long-range benchmark rate of 80 percent.

Summary

All of the rates for CHS's performance measures exceeded AHCCCS's CYE 2007 goals. Furthermore, none of the performance measures required a CAP. These two findings evidence clear strengths for the Contractor for the performance measures. However, CHS's performance on the retinal exams measure for diabetic members suggests a substantive decline from the CYE 2006 performance rate and should be targeted for interventions in order to prevent further declines.

Evercare Select

ES serves eligible, enrolled members in Maricopa, Mohave, Coconino, Apache, and Navajo counties and has contracted with AHCCCS since October 1, 1989. During the current measurement period the Contractor had approximately 5,100 members.

Findings

Table 7-2 presents the performance measure rates for ES. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-2—Performance Measurement Review *for* ES

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change[A]	Significance Level[B]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[C]	90.0%	79.3%	-11.9%	p=.075	84%	85%	98%
Diabetes Management—HbA1c Testing	69.3%	**82.4%**	**18.8%**	**p=.001**	75%	77%	88%
Diabetes Management—Lipid Screening	66.5%	**78.8%**	**18.5%**	**p=.003**	76%	78%	85%
Diabetes Management—Retinal Exams	85.6%	**65.5%**	**-23.5%**	**p<.001**	45%	47%	64%
EPSDT Participation	56.5%	42.4%	-25.0%	p=.150	50%	53%	80%

[A] The relative percent change calculation is based on greater precision than presented in the current table.

[B] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[C] HCBS=Home and Community-Based Services.

Using the CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, ES returned mixed results for its performance measure rates. The rate from the Initiation of HCBS (79.3 percent) dropped below the CYE 2007 MPS of 84 percent. The 11.9 percent change in the rate for this measure (90.0 percent in CYE 2006 to 79.3 percent in CYE 2007) resulted in a CAP. Additionally, while the change in performance was not statistically significant (p=.075), the result was close to the traditionally accepted maximum test value of p≤.05, suggesting that ES consider implementing additional quality improvement efforts to limit the risk of a statistically significant drop in the future.

ES's performance on the first two diabetes management measures (i.e., HbA1c Testing and Lipid Screening) significantly improved ($p \leq .05$) in CYE 2007. Moreover, both measures' rates (82.4 percent and 78.8 percent, respectively) exceeded AHCCCS's CYE 2007 MPSs and goals. The improvements for both rates were substantively large and statistically significant. Conversely, ES's rate for the Retinal Exams measure decreased by a substantively large and statistically significant amount (85.6 percent in CYE 2006 to 65.5 percent in CYE 2007). However, the Contractor's performance still exceeded the AHCCCS long-range benchmark of 64 percent. Although a CAP has not been required for this measure (due to its rate still exceeding the MPS), ES should investigate the reason for the decline and take appropriate actions to reverse it.

Finally, the EPSDT Participation rate changed from 56.5 percent during the previous measurement period (CYE 2006) to 42.4 percent in CYE 2007. This change was not statistically significant ($p = .150$). The CYE 2007 EPSDT Participation rate (42.4 percent) dropped below the AHCCCS MPS rate of 50 percent. Having been greater than the AHCCCS goal (53 percent) one year earlier, this performance measure highlights an opportunity for improvement.

CAPs

ES has two required CAPs based on the results of the CYE 2007 performance measures, one for the Initiation of HCBS and another for EPSDT Participation. The rates for both measures had been above the MPS in CYE 2006.

Strengths

The results for HbA1c Testing and for Lipid Screening show that these measures are strengths for ES. The rates for both of these measures improved significantly ($p \leq .05$) and exceeded both AHCCCS's CYE 2007 MPSs and goals.

Opportunities for Improvement and Recommendations

Two opportunities for improvement are highlighted in the current results. Both the Initiation of HCBS and EPSDT Participation performance measures required CAPs during the CYE 2007 review. However, previously, ES demonstrated strengths in these areas by exceeding both the MPSs and goals in CYE 2006. For this reason, recommendations for specific improvement are warranted. Specifically, it is recommended that ES conduct a root-cause analysis of the factors contributing to the failure to perform at or above the minimum required levels by evaluating any structural or procedural aspects of care and population demographics that changed between the two contract cycles. Those elements that can be causally related to the decline in rates should be targeted as quality improvement opportunities. Additionally, ES should work with other Contractors to identify best practices based on their experience and address any identified deficiencies in the provision of these services.

Summary

ES's performance on these measures showed mixed results. The rates for two Diabetes Management measures (HbA1c Testing and Lipid Testing) saw substantively large and statistically significant increases while two measures with previously high rates saw declines that resulted in

required CAPs (i.e., Initiation of HCBS and EPSDT Participation). The rate for Retinal Exams also significantly declined, but was still above the AHCCCS long-range benchmark.

Mercy Care Plan

MCP serves eligible ALTCS members in the Maricopa GSA and has contracted with AHCCCS since 2000 for the ALTCS program. During the current measurement period, the Contractor had approximately 8,200 ALTCS members.

Findings

Table 7-3 presents the performance measure rates for MCP. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-3—Performance Measurement Review *for* MCP

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change[A]	Significance Level[B]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[C]	85.6%	**94.3%**	**10.2%**	**p=.006**	84%	85%	98%
Diabetes Management—HbA1c Testing	77.1%	82.2%	6.5%	p=.127	75%	77%	88%
Diabetes Management—Lipid Screening	78.6%	80.6%	2.6%	p=.542	76%	78%	85%
Diabetes Management—Retinal Exams	51.7%	52.3%	1.3%	p=.875	45%	47%	64%
EPSDT Participation	48.0%	58.5%	21.8%	p=.071	50%	53%	80%

[A] The relative percent change calculation is based on greater precision than presented in the current table.

[B] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[C] HCBS=Home and Community-Based Services.

All five of the rates for MCP's CYE 2007 performance measures were positioned between the AHCCCS goals and long-range benchmarks, and all five rates showed relative increases from their CYE 2006 levels. Further, the increase in the Initiation of HCBS rate was statistically significant. (p=.006), and the rate for EPSDT Participation increased by an amount that approached statistical significance (p=.071). These results show continued improvement and strong overall performance by MCP.

CAPs

MCP did not have any CAPs required for the performance measure review during the current contract period. Importantly, while the EPSDT Participation measure required a CAP during the

previous contract period, the CYE 2007 rate (58.5 percent) increased such that it exceeded AHCCCS's MPS and goal (50 percent and 53 percent, respectively).

Strengths

The entire performance measure set is a recognized strength for MCP. The rates for all five measures during CYE 2007 achieved values between the AHCCCS goals and the AHCCCS long-range benchmarks; all measures exceeded AHCCCS's MPS.

Opportunities for Improvement and Recommendations

The results from the performance measure review do not suggest any opportunities for improvement at this time. The CYE 2007 rates for all measures were sufficiently high and did not indicate a decline. Consistent with ongoing improvement and maintenance of current performance, HSAG recommends that MCP regularly monitor and review its rates to ensure continued success.

Summary

MCP demonstrated success across all of the performance measures by exceeding the AHCCCS goals. In addition, each measure's rate exhibited a relative increase, with the rate for Initiation of HCBS showing a statistically significant increase.

Pima Health Systems

PHS serves eligible, enrolled members in Pima and Santa Cruz counties and has contracted with AHCCCS since October 1, 1988. During the current measurement period, the Contractor had approximately 3,900 members.

Findings

Table 7-4 presents the performance measure rates for PHS. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-4—Performance Measurement Review *for* PHS

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change[A]	Significance Level[B]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[C]	91.9%	97.7%	6.3%	p=.093	84%	85%	98%
Diabetes Management—HbA1c Testing	70.6%	73.9%	4.7%	p=.427	75%	77%	88%
Diabetes Management—Lipid Screening	75.3%	80.1%	6.3%	p=.221	76%	78%	85%
Diabetes Management—Retinal Exams	61.9%	62.4%	0.8%	p=.915	45%	47%	64%
EPSDT Participation	64.9%	55.2%	-15.0%	p=.286	50%	53%	80%

[A] The relative percent change calculation is based on greater precision than presented in the current table.

[B] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the p-value ≤ .05.

[C] HCBS=Home and Community-Based Services.

Table 7-4 indicates that PHS has generally high rates, with only one measure (Diabetes Management—HbA1c Testing) requiring a CAP in CYE 2007. The rates for the remaining performance measures exceeded the AHCCCS goals and approached AHCCCS's long-range benchmarks. Although none of the rates changed significantly in CYE 2007, a potential decrease in the EPSDT Participation rate was illustrated by a relative decline of 15.0 percent between the most recent measurement periods. Quality improvement efforts at this point might prevent a statistically significant decline in the future.

CAPs

PHS's performance on the Diabetes Management—HbA1c Testing measure required the continuation of a CAP from the previous contract period. However, the estimates in Table 7-4 suggest improvement even though a statistically significant increase in rates had not been experienced. Although not shown in Table 7-4, the CYE 2005 rate (75.5 percent) was above the current MPS of 75 percent. This finding suggests that PHS has the internal processes and procedures necessary to return sufficiently high results and meet minimum program requirements. Additionally, due to substantive increases in the Diabetes Management—Lipid Screening rate during CYE 2007, the previously required CAP is no longer needed since PHS's 2007 performance exceeded AHCCCS's MPS.

Strengths

The rates for Initiation of HCBS, Diabetes Management—Lipid Screening, Diabetes Management—Retinal Exams, and EPSDT Screening exceeded AHCCCS's MPSs and goals. Additionally, some of the performance measure rates approached the AHCCCS long-range benchmarks. Using AHCCCS's standards as the performance frames of reference, PHS is achieving success on four of the five performance measures.

Opportunities for Improvement and Recommendations

The required CAP for the Diabetes Management—HbA1c Testing measure for PHS is a clear opportunity for improvement. Contractor rates for HbA1c Testing reflect performance related to timeliness and access. Improving the HbA1c Testing rate is frequently accomplished by implementing a combination of interventions. For example, the Contractor should review and enhance its current processes for, or explore adding additional processes associated with, physician and/or member reminder systems. These notification systems prompt providers to schedule appropriate tests and services at recommended intervals and prompt members to keep scheduled appointments. Additionally, the Contractor should evaluate members' current access to services to identify and remove any potential barriers to care. Improved access to labs can be achieved by extending service hours, contracting with additional facilities, and/or enhancing transportation options. Each of these options make it easier and more convenient for members to receive this important test. Both types of interventions should work to improve the overall rate of HbA1c Testing for PHS.

Summary

Overall, PHS showed statistically flat results for all reported performance measures. Nonetheless, four of the five performance measures continued to exceed the AHCCCS MPS, with only one rate requiring a CAP. One of the previously required CAPs (Diabetes Management—Lipid Screening) was no longer required due to a relative increase in performance. Additionally, with targeted interventions, longitudinal improved performance for the one measure that still required a CAP (Diabetes Management—HbA1c Testing) could be reached for the next contract reporting period.

Pinal/Gila Long Term Care

P/GLTC serves eligible, enrolled members in Pinal and Gila counties and has contracted with AHCCCS since October 1, 1990. During the current measurement period, the Contractor had approximately 1,250 members.

Findings

Table 7-5 presents the performance measure rates for P/GLTC. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-5—Performance Measurement Review *for* P/GLTC

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[B]	84.1%	94.6%	12.5%	p=.101	84%	85%	98%
Diabetes Management—HbA1c Testing	90.2%	**80.0%**	**-11.3%**	**p=.036**	75%	77%	88%
Diabetes Management—Lipid Screening	90.2%	91.0%	0.9%	p=.838	76%	78%	85%
Diabetes Management—Retinal Exams	84.8%	77.0%	-9.2%	p=.146	45%	47%	64%
EPSDT Participation	35.3%	100%	183.3%	N/A[C]	50%	53%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between the performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] HCBS=Home and Community-Based Services.

[C] A value of "N/A" indicates that statistical testing was not done due to the small sample size (i.e., n = 19).

Table 7-5 illustrates two primary results. First, although no statistical testing was performed due to a small sample size, the EPSDT Participation rate increased 183.3 percent from CYE 2006 (35.3 percent) to CYE 2007 (100.0 percent). This change in rates moved P/GLTC's performance above the AHCCCS long-range benchmark of 80 percent. Second, the rate for the Diabetes Management—HbA1c Testing performance measure significantly declined from 90.2 percent to 80.0 percent in CYE 2007 (p =.036). Although the CYE 2007 rate is still above the AHCCCS goal (77 percent), it had previously exceeded the AHCCCS long-range benchmark in CYE 2006.

The rates for the remaining measures were statistically flat, and varied in their relative increases and decreases compared to CYE 2006. The Initiation of HCBS and Diabetes Management—Lipid Screening measures changed positively while the rate of Diabetes Management—Retinal Exams

changed negatively. Overall, P/GLTC's performance on three of the measures (Lipid Screening and Retinal Exams within Diabetes Management and EPSDT Participation) exceeded the AHCCCS long-range benchmarks while performance on the other two measures (Initiation of HCBS and HbA1c Testing) were above the AHCCCS goals. All performance measure rates, however, were above the AHCCCS MPS.

CAPs

P/GLTC did not have any CAPs required for the performance measures reviewed during CYE 2007. This includes the EPSDT Participation measure, which required a CAP in CYE 2006.

Strengths

All of the reported rates for the CYE 2007 performance measures exceeded the AHCCCS goals, and three of the five rates exceeded the AHCCCS long-range benchmarks. These results indicate that these performance measures represent an overall strength for P/GLTC.

Opportunities for Improvement and Recommendations

The statistically significant decline in the Diabetes Management—HbA1c Testing rate identifies an opportunity for improvement, but one that is tempered by the finding that the current rate of 80.0 percent is still above the AHCCCS goal for CYE 2007. However, without evidence showing that the reported decline is either temporary or has stabilized, P/GLTC should consider conducting a root-cause analysis to determine actionable interventions and intercede to reverse the decline.

Contractor rates for HbA1c Testing reflect performance related to timeliness and access. Improving the HbA1c Testing rate is frequently accomplished by implementing a combination of interventions. For example, the Contractor should review and enhance current, or explore implementing new processes associated with, physician and/or member reminder systems. These notification systems prompt providers to schedule appropriate tests and services at recommended intervals and prompt members to keep scheduled appointments. Additionally, the Contractor should evaluate members' current access to services to identify and remove any potential barriers to care. Improved access to labs can be achieved by extending service hours, contracting with additional facilities, and/or enhancing transportation options. These options make it easier and more convenient for members to receive this important test. Both types of interventions should contribute to improving the overall rate of HbA1c Testing for P/GLTC.

Summary

Overall, P/GLTC's results across all performance measures indicate areas of strength. In all cases, rates exceeded AHCCCS's MPSs and goal. Notably, the rates for Diabetes Management—Lipid Screening, Diabetes Management—Retinal Exams, and EPSDT Participation all exceeded AHCCCS's long-range benchmarks.

Yavapai County Long Term Care

YCLTC serves eligible, enrolled members in Yavapai County and has contracted with AHCCCS since October 1, 1993. During the current measurement period, the Contractor had approximately 930 members.

Findings

Table 7-6 presents the performance measure rates for YCLTC. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-6—Performance Measurement Review *for* YCLTC

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change[A]	Significance Level[B]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[C]	92.3%	95.0%	2.9%	p=1.000	84%	85%	98%
Diabetes Management—HbA1c Testing	67.7%	77.3%	14.1%	p=.152	75%	77%	88%
Diabetes Management—Lipid Screening	46.2%	**77.3%**	**67.1%**	**p<.001**	76%	78%	85%
Diabetes Management—Retinal Exams	54.8%	56.8%	3.6%	p=.789	45%	47%	64%
EPSDT Participation	93.3%	100%	7.1%	N/A[D]	50%	53%	80%

[A] The relative percent change calculation is based on greater precision than presented in the current table.

[B] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[C] HCBS=Home and Community-Based Services.

[D] A value of "N/A" indicates that statistical testing was not done due to the small sample size (i.e., n = 14).

YCLTC has shown excellent progress with the performance measures. Rates for the two measures requiring CAPs from CYE 2006 (Diabetes Management—HbA1c Testing and Diabetes Management—Lipid Screening) have improved. This finding is evidenced by the 67.1 percent increase in the rate for Lipid Screening in CYE 2007, which was 31.1 percentage points higher, a statistically significant increase (p<.001). The rate for HbA1c Testing increased by 14.1 percent in CYE 2007 and exceeded the AHCCCS MPS and goal; however, the difference from the previous measurement period was not statistically significant.

All five of the performance measures rates for YCLTC exceeded the CYE 2007 MPS for the current measurement period. In addition, rates for Initiation of HCBS, Diabetes Management—HbA1c Testing, and Diabetes Management—Retinal Exams were all above the AHCCCS goals of 85 percent, 77 percent, and 47 percent, respectively. Although the measure only included 14 eligible members, the rate for EPSDT Participation was above the AHCCCS long-range benchmark.

CAPs

YCLTC received no CAPs for CYE 2007 and, during the reporting period, resolved two CAPs from CYE 2006 (Diabetes Management—HbA1c Testing and Diabetes Management—Lipid Screening).

Strengths

Overall, the performance measures were assessed as strengths for YCLTC. The Contractor required no CAPs and had one measure showing a CYE 2007 rate in excess of the AHCCCS long-range benchmark (EPSDT Participation). Additionally, three of the other measures (Initiation of HCBS, Diabetes Management—HbA1c Testing, and Diabetes Management—Retinal Exams) exhibited rates above the CYE 2007 AHCCCS goals.

Opportunities for Improvement and Recommendations

While improvement is always encouraged, based on YCLTC's strong results for the CYE 2007 review and the changes in its rates from CYE 2006 to CYE 2007, there are no specific areas within the performance measure review that indicate an opportunity for improvement.

Summary

YCLTC demonstrated a high level of success with all of the performance measures as illustrated by four of the five rates exceeding the AHCCCS goals, and all of the rates exceeding AHCCCS's MPS. Additionally, although only the Diabetes Management—Lipid Screening rate experienced a statistically significant increase since CYE 2006, the changes present in the remaining measures for CYE 2007 highlighted relative improvement. The Contractor's performance rates successfully resolved two CAPs from CYE 2006. Finally, the CYE 2007 rate for EPSDT Participation reached 100 percent, although statistical testing was not completed due to a small sample size.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

DES/DDD serves eligible, enrolled members in all 15 counties in Arizona and has contracted with AHCCCS since 1989. During the current measurement period, the Contractor had approximately 19,200 members.

Findings

Table 7-7 presents the performance measure rates for DES/DDD. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-7—Performance Measurement Review *for* DES/DDD

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change[A]	Significance Level[B]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	69.6%	**68.1%**	**-2.1%**	**p=.037**	73%	75%	97%
12–24 Months	90.1%	**77.6%**	**-13.9%**	**p=.050**	N/A[D]	N/A[D]	N/A[D]
25 Months–6 Years	69.2%	67.7%	-2.1%	p=.244	N/A[D]	N/A[D]	N/A[D]
7–11 Years	67.9%	67.6%	-0.4%	p=.827	N/A[D]	N/A[D]	N/A[D]
12–19 Years	70.9%	68.8%	-3.0%	p=.062	N/A[D]	N/A[D]	N/A[D]
Well-Child Visits—First 15 months[C]	N/R	N/R	N/R	N/R	N/A[D]	N/A[D]	N/A[D]
Well-Child Visits—3, 4, 5, 6 Years	38.4%	**43.8%**	**14.0%**	**p<.001**	42%	46%	80%
Adolescent Well-Child Visits	28.3%	28.8%	1.7%	p=.637	31%	33%	50%
Annual Dental Visit	41.1%	40.7%	-1.1%	p=.549	39%	41%	56%
EPSDT Participation	50.6%	**55.2%**	**9.1%**	**p<.001**	51%	54%	80%

[A] The relative percent change calculation is based on greater precision than presented in the current table.

[B] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[C] Rates for this measure were not reported (N/R) because the Contractor did not have a large enough population that met continuous enrollment criteria.

[D] A value of "N/A" was used to identify where MPS, Goals, and Long-Range have not been established.

Table 7-7 shows mixed but declining performance overall for six of nine comparable measures as evidenced by the relative declines in rates for the Children's Access to PCPs performance measures. Importantly, two rates exhibited statistically significant declines between CYE 2006 and CYE 2007 (Children's Access to PCPs [total] and children 12–24 months of age). Additionally, the decline for Children's Access to PCPs for adolescents 12–19 years of age approached statistical significance (p=.062). However, programming changes for the Children's Access to PCPs measure implemented by AHCCCS in order to conform to current HEDIS requirements may have affected the results for these measures. Although performance on the Annual Dental Visit measure changed 1.1 percent from CYE 2006 (41.1 percent) to CYE 2007 (40.7 percent), DES/DDD's rate was still above the MPS established by AHCCCS.

In contrast to the declines cited above, the Well-Child Visits—3, 4, 5, 6 Years rate improved 14.0 percent to 43.8 percent, representing a statistically significant increase. This improvement placed DES/DDD's rate above the AHCCCS MPS. The Annual EPSDT Participation rate also increased significantly from 50.6 percent in CYE 2006 to 55.2 percent in CYE 2007, a 9.1 percent change. This rate currently exceeds both the AHCCCS MPS and goal for CYE 2007 of 51 percent and 54 percent, respectively. The Adolescent Well-Child Visits rate remained statistically unchanged and below the AHCCCS MPS.

CAPs

Of the five performance measures shown in Table 7-7 with a corresponding MPS, two measures required a CAP—Children's Access to PCPs (total), and Adolescent Well-Child Visits. The first of these measures showed a statistically significant decrease from CYE 2006 to CYE 2007, while the second measure was statistically unchanged and remained below the MPS. However, the decrease in the rate for the Children's Access to PCPs measure may be attributed to programming changes implemented during the current measurement period to better conform to HEDIS methodology. In CYE 2006, DES/DDD was required to establish four CAPs for the five measures shown with a corresponding MPS. The decline in the total number of CAPs to two represents an improvement for DES/DDD.

Strengths

The rate for Annual EPSDT Participation reached and exceeded the AHCCCS goal in addition to demonstrating a statistically significant increase from CYE 2006. For these reasons, the Annual EPSDT Participation performance measure is considered a strength for DES/DDD. No other rate reached the AHCCCS goals, although the Well-Child Visits—3, 4, 5, 6 Years also increased significantly, exceeding the AHCCCS MPS in CYE 2007.

Opportunities for Improvement and Recommendations

Children's Access to PCPs represents an overarching opportunity for improvement with a significant decline in the overall rate and corresponding decreases in the individual age-group rates. Access can be constrained by a wide number of provider and member characteristics. Real performance can be particularly difficult to assess and improve for the DES/DDD population since interventions typically employed to improve member access to needed appointments can be more difficult to operationalize. This is because member information about the medical care members

receive is not all available, or available in a timely manner, to DES/DDD and its providers. As such, the Contractor should consider establishing a work group to conduct a formal study of children's access to PCPs that includes a barrier analysis and other structural elements recommended within the CMS protocol for focused studies.[7-2]

The second area assessed as an opportunity for improvement was Adolescent Well-Child Visits. Improving this measure may highlight the same issues, difficulties, barriers, and potential solutions noted for Children's Access to PCPs. Therefore, the Contractor should include both measures in the recommended focused study to identify and understand the structural and environmental conditions impacting access to services and the extent to which DES/DDD's performance rates appear to be attributable to variables beyond its direct influence or control.

Summary

Of the five performance measures with an MPS, the rates for two measures showed statistically significant increases (Annual EPSDT Participation and Well-Child Visits—3, 4, 5, 6 Years) and the rate for one measure showed a statistically significant decline (Children's Access to PCPs [total]). The decreasing rate for Children's Access to PCPs was responsible for one of two required CAPs. However, caution should be used when evaluating this decrease since programming changes were implemented during the current measurement period to better conform to HEDIS methodology. These changes may have affected the reported rate for Children's Access to PCPs. The CAP required for the second measure was for Adolescent Well-Child Visits.

[7-2] Conducting Focused Studies Of Health Care Quality (Final Protocol, Version 1.0, May 1, 2002, from the Centers for Medicare & Medicaid Services—CMS).

Comparative Results for ALTCS EPD Contractors

AHCCCS calculated and reported the ALTCS EPD Contractor rates for the same set of performance measures in CYE 2007 that it did in CYE 2006. In general, the methodologies for generating the rates remained constant over the two-year period, ensuring the comparability of the results across years. However, the programming for the Diabetes Management—Retinal Exam measure was modified by AHCCCS in order to better conform to current HEDIS requirements. This modification may have adversely affected the CYE 2007 rates for these measures; therefore, the results should be interpreted with caution.

Findings

Table 7-8 presents the mean rates across the six ALTCS EPD Contractors. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS's CYE 2007 MPSs, goals, and long-range benchmarks.

Table 7-8—Performance Measurement Review *for* ALTCS EPD Contractors

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Initiation of HCBS[B]	89.1%	92.5%	3.8%	p=.069	84%	85%	98%
HbA1c Testing	74.8%	**79.7%**	**6.6%**	**p=.007**	75%	77%	88%
Lipid Screening	73.6%	**80.9%**	**9.9%**	**p<.001**	76%	78%	85%
Retinal Exams	66.6%	**60.4%**	**-9.4%**	**p=.003**	45%	47%	64%
EPSDT Participation	56.5%	59.8%	5.8%	p=.413	50%	53%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between performance during the previous measurement period and performance during the current measurement period. Statistical significance is traditionally reached when the *p* value ≤ .05. Rates in bold indicate statistical significance.

[B] HCBS=Home and Community-Based Services.

Table 7-8 shows general improvement across the measures, but mixed performance statewide. Two of the five measures showed statistically significant gains (Diabetes Management—HbA1c Testing and Diabetes Management—Lipid Screening), one measure (Initiation of HCBS) displayed results suggestive of improvement, one remained statistically unchanged (EPSDT Participation), and one of the measures exhibited a statistically significant decline (Diabetes Management—Retinal Exams). However, caution should be used when evaluating this decrease since data collection processes were modified in the current measurement period to better conform to HEDIS methodology.

However, using AHCCCS's CYE 2007 MPSs, goals, and the long-range benchmarks as frames of reference, the ALTCS EPD Contractors are performing well overall. The average CYE 2007 performance measure rates across all six ALTCS EPD Contractors with reported data showed rates above the CYE 2007 AHCCCS goals. Nonetheless, the ALTCS EPD Contractor rate for Diabetes Management—Retinal Exams was previously above the AHCCCS long-range benchmark, but

declined below it for CYE 2007. However, the decrease in these rates may be attributed to programming changes implemented during the current measurement period to better conform to HEDIS methodology. The statistically significant decline in this rate represents an important statewide opportunity for improvement.

Figure 7-1 presents the average rates for the performance measures for the six ALTCS EPD Contractors. This figure presents the average weighted rates for the last two measurement periods across the five performance measures.

Figure 7-1—Current and Previous Average Performance Measure Rates *for* All ALTCS EPD Contractors[7-3]

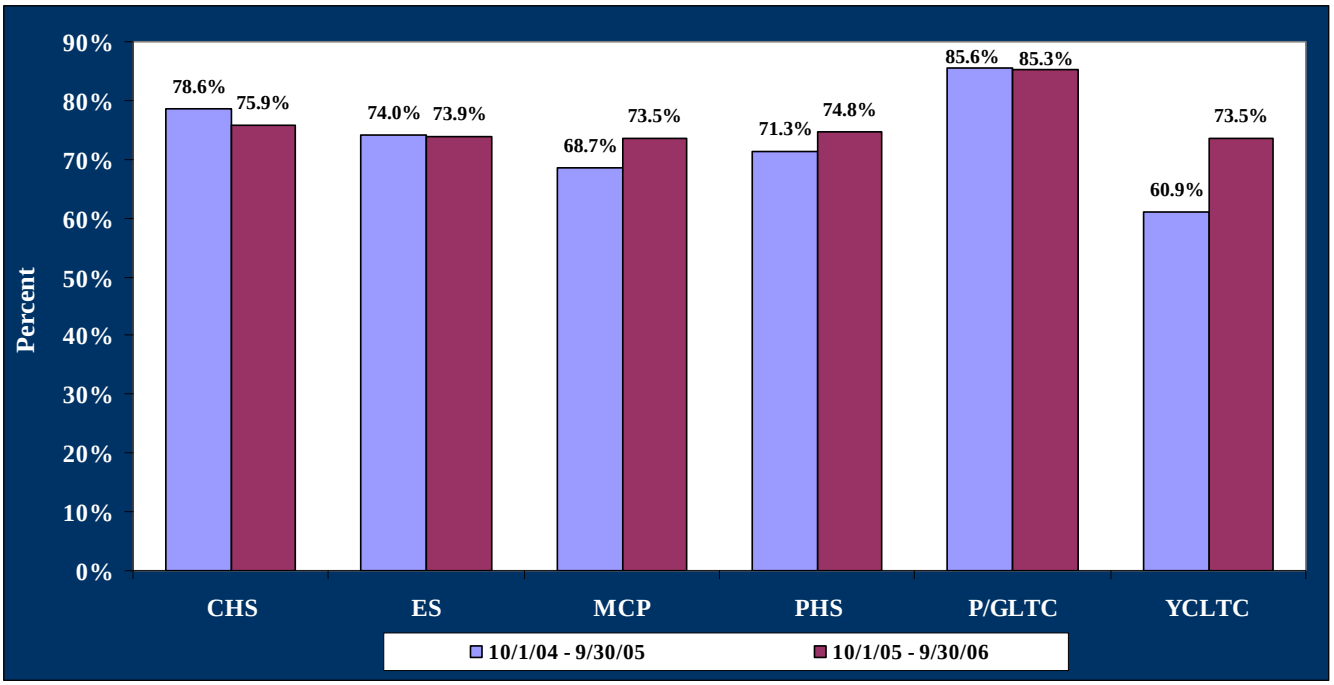


Figure 7-1 shows that the mean Contractor rate for the performance measures has increased for three of the six EPD Contractors (MCP, PHS, and YCLTC) and decreased for the other three (CHS, ES, and P/GLTC). Additionally, the magnitude of the increases appears to offset the decreases, most notably due to the increases exhibited in the rates for MCP and YCLTC. Overall, the ALTCS EPD Contractors appear to have made progress in improving their rates on the performance measures.

Although there was overall improvement across ALTCS EPD Contractors, there was also opportunity for improvement. Figure 7-2 presents the CYE 2007 MPS, the CYE 2006 results (based on the measurement period from October 1, 2004, to September 30, 2005), and the CYE 2007 results (based on the measurement period from October 1, 2005, to September 30, 2006) for each measure.

[7-3] The Contractor names are abbreviated as follows: CHS=Cochise Health Systems, ES=Evercare Select, MCP=Mercy Care Plan, PHS=Pima Health Systems, P/GLTC=Pinal/Gila Long Term Care, and YCLTC=Yavapai County Long Term Care.

Figure 7-2—Current and Previous Performance Measure Rates *for* All ALTCS EPD Contractors

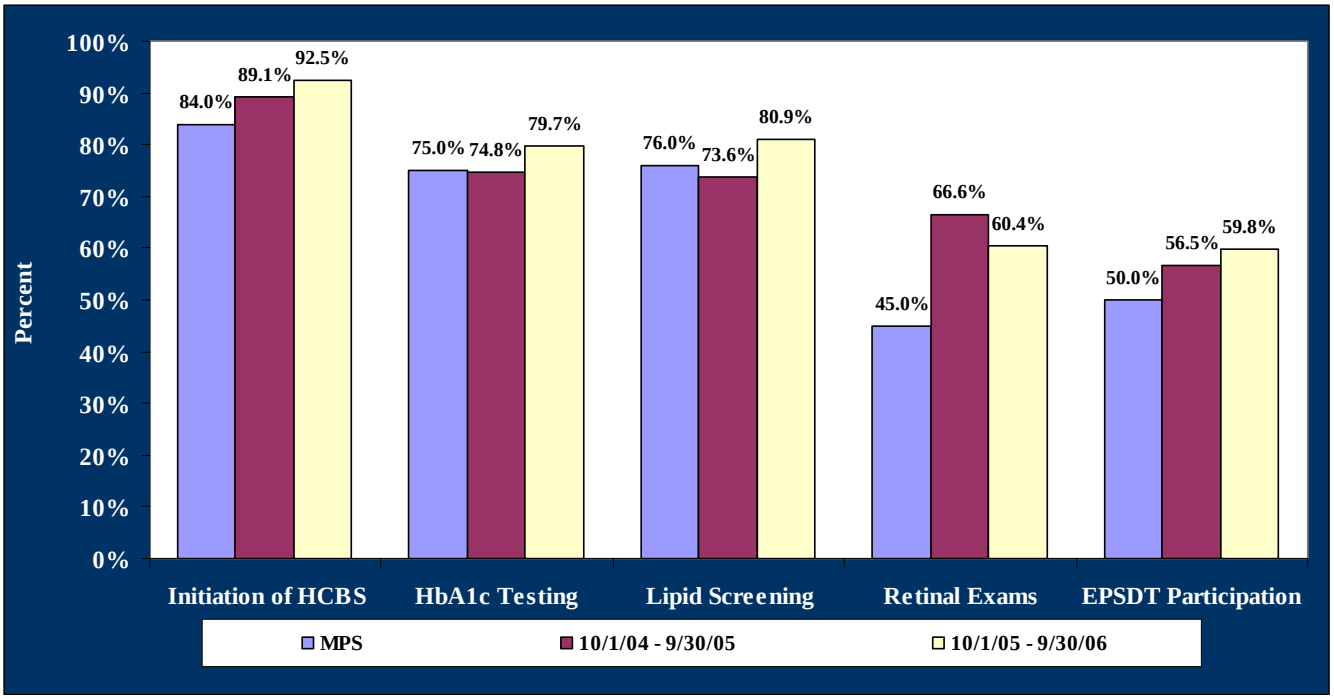


Figure 7-2 shows two important results. First, the average rate for every measure was above the CYE 2007 MPS. These average rates were also above AHCCCS's goals. Second, rates for four of the five measures increased. Diabetes Management—Retinal Exams was the exception. For this reason, performance for Diabetes Management—Retinal Exams is an overall opportunity for improvement for ALTCS EPD Contractors. However, the finding is somewhat tempered by an especially large gain between CYE 2005 and CYE 2006, which noted an increase from 51.1 percent (CYE 2005) to 66.6 percent (CYE 2006). Additionally, the decrease in these rates may be attributed to programming changes implemented during the current measurement period to better conform to HEDIS methodology.

CAPs

Table 7-9 presents ALTCS EPD Contractors' required CAPs for the previous and the current contract periods. The table shows each of the performance measures, the previous number of CAPs required, the CYE 2006 MPS, the current number of CAPs required, and the CYE 2007 MPS. Although separately shown, the MPS remained constant between CYE 2006 and CYE 2007.

Table 7-9—Performance Measures—Corrective Action Plans Required for ALTCS EPD Contractors				
	CYE 2006		CYE 2007	
Performance Measure	Number of CAPs (10/1/04–9/30/05)	AHCCCS Minimum Performance Standard	Number of CAPs (10/1/05–9/30/06)	AHCCCS Minimum Performance Standard
Initiation of HCBS[A]	0	84%	1	84%
Diabetes Management—HbA1c Testing	3	75%	1	75%
Diabetes Management—Lipid Screening	3	76%	0	76%
Diabetes Management—Retinal Exam	0	45%	0	45%
EPSDT Participation	2	50%	1	50%
Total Performance Measure CAPs	**8**		**3**	

[A] HCBS=Home and Community-Based Services.

Table 7-9 shows a marked reduction in the number of required CAPs for the five performance measures across the six ALTCS EPD Contractors, decreasing from eight CAPs in CYE 2006 to three CAPs in CYE 2007. This reduction represents a 63 percent improvement in the number of required CAPs, including the resolution of all three previously required CAPs for Diabetes Management—Lipid Screening, two of the three CAPs for Diabetes Management—HbA1c Testing, and one of the two CAPs for EPSDT Participation. Nonetheless, where the previous measurement cycle did not show any required CAPs for Initiation of HCBS, the current assessment shows one required CAP for ES.

Strengths

ALTCS EPD Contractors have clearly shown strength in the following performance measures: Initiation of HCBS, Diabetes Management—HbA1c Testing, Diabetes Management—Lipid Screening, and EPSDT Participation. Results for each of these measures displayed rates that improved upon CYE 2006 performance levels and exceeded the CYE 2007 MPS. Of these four measures, Diabetes Management—Lipid Screening showed the largest improvement, increasing from 73.6 percent in CYE 2006 to 80.9 percent in CYE 2007.

Although indicating somewhat decreased performance in the current measurement period, Contractor performance for the Diabetes Management—Retinal Exams measure did not require CAPs in either the previous or the current review cycles, and still greatly exceeded the MPS for both years. Additionally, the decline in performance for this measure may be attributable to programming changes implemented to better conform to HEDIS methodology. This finding suggests that performance on the measure is a relative strength for ALTCS EPD Contractors. Nonetheless, the current decline strongly suggests an opportunity to improve the overall rate to at least the previous level.

Opportunities for Improvement and Recommendations

Because of the decline in the average rates achieved between the two measurement periods, performance for Diabetes Management—Retinal Exams presents an opportunity for improvement. Overall, no other ALTCS EPD Contractor-wide opportunity for improvement is evident from the current performance measure review.

Summary

The results suggest substantive improvements for four of the five performance measure rates and an opportunity to improve the fifth rate (Diabetes Management—Retinal Exams). Overall, the EPD Contractors have performed well by generally exceeding the AHCCCS goals.

In accordance with 42 CFR 438.240(d), AHCCCS contractually requires Contractors to have a QAPI program that: (1) includes an ongoing program of PIPs designed to achieve favorable effects on health outcomes and enrollee satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating the effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

The CFR citation above also requires each PIP to be completed in a reasonable time to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

One of the three external review-related activities mandated by the BBA and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPS that were required by the state and under way during the preceding 12 months. The requirement at 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities. AHCCCS elected to conduct the functions associated with the BBA mandatory activity of validating its Contractors' PIPs. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its PIP data collection, calculation, and validation activities to prepare this 2006–2007 annual report.

Conducting the Review

AHCCCS requires Contractors to participate in AHCCCS-selected PIPs. The mandated PIP topics:

- Are selected through the analysis of internal and external data and trends and through Contractor input.
- Take into account comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members.

AHCCCS performs data collection and analysis for baseline and successive measurements, and reports performance results of mandated PIPs for each Contractor and across Contractors.

In CYE 2007, AHCCCS completed its analysis of the first remeasurement of the ALTCS EPD Contractors' performance under a PIP to improve management of comorbid/coexisting diseases. Because DES/DDD had not yet met AHCCCS's requirements to complete its PIP, Immunization Completion Rates by 24 Months of Age, AHCCCS required DES/DDD to continue to report its actions to improve performance on this PIP. AHCCCS continued to collect and calculate DES/DDD's PIP performance results.

Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

- Ensured that each Contractor had an ongoing performance improvement program of projects that focused on clinical and/or nonclinical areas for the services it furnished to members.
- Ensured that each Contractor measured performance using objective and quantifiable quality indicators.
- Ensured that each Contractor implemented system wide interventions to achieve improvement in quality.
- Evaluated the effectiveness of each Contractor's interventions.
- Ensured that each Contractor planned and initiated activities to increase or sustain its improvement.
- Ensured that each Contractor reported to the State data/information it collected for each project in a reasonable period to allow timely information on the status of PIPs.
- Calculated and validated the PIP results from the Contractor data/information.
- Reviewed the impact and effectiveness of each Contractor's performance improvement program.
- Required each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for seven of the nine ALTCS EPD and DES/DDD Contractors' performance with respect to the AHCCCS-selected PIPs. Two of the eight current EPD Contractors (Bridgeway Health Solutions and SCAN Long Term Care) had not been AHCCCS Contractors long enough for AHCCCS to have PIP data available for them. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- Determine Contractor performance on the AHCCCS-selected PIPs.
- Provide data from analyzing the PIP results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide across the Contractors.

Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide across Contractors

Methodology for Conducting the Review

AHCCCS develops a methodology to measure performance in a standardized way across Contractors for each mandated PIP and follows quality control processes to ensure the collection of valid and reliable data. The study indicators AHCCCS selects for each PIP are based on current clinical knowledge or health services research. The methodology states the study question, the population(s) included, any sampling methods, and methods to collect the data. AHCCCS collects the data from the encounter subsystem of its PMMIS system. To ensure the reliability of the data, AHCCCS conducts data validation studies to evaluate the completeness, accuracy, and timeliness of the data. AHCCCS may also request that Contractors collect additional data (e.g., the diabetes PIP).

In these cases, AHCCCS requires the Contractors to submit documentation to verify that indicator criteria were met.

Following data collection and encounter validation, AHCCCS reports Contractor results and an analysis and discussion of possible interventions. Contractors conduct additional analysis of their data and performance improvement interventions. Remeasurement of performance is conducted in the third year of a PIP. AHCCCS requires Contractors to evaluate the effectiveness of their interventions and report to AHCCCS the results of their evaluation and any new or revised interventions. Contractors whose performance does not demonstrate improvement from baseline to remeasurement are required to report to AHCCCS their proposed actions to revise, replace, and/or initiate new interventions.

To determine if improved Contractor performance is sustained, AHCCCS conducts a second remeasurement. If Contractors do not sustain their performance, they must report to AHCCCS their planned changes to interventions.

If results of the second remeasurement demonstrate that a Contractor's performance was both improved and the improvement was sustained, AHCCCS considers the PIP closed for that Contractor. If the Contractor's performance was not improved and the improvement was not sustained, the PIP remains open and continues for another remeasurement cycle. When a PIP is considered closed for a Contractor, the Contractor's final report and any follow-up or ongoing activities are due 180 days after the end of the project (typically the end of the contract year). AHCCCS prepared a standardized format for documenting PIP activities (Performance Improvement Project Reporting Format). AHCCCS encourages Contractors to use the PIP Reporting Format to document their analyses of baseline and remeasurement results, implementation of interventions, and assessment of improvement.

AHCCCS conducted its review and assessment of Contractor performance using the applicable criteria found in *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002). The protocol includes 10 distinct steps:

- Review the selected study topic(s)
- Review the study question(s)
- Review the selected study indicator(s)
- Review the identified study population(s)
- Review the sampling methods (if sampling was used)
- Review the Contractor's data collection procedure
- Assess the Contractor's improvement strategies
- Review the data analysis and the interpretation of the study's results
- Assess the likelihood that reported improvement is real improvement
- Assess whether the Contractor has sustained its documented improvement.

The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable and not acceptable examples of each step.

As noted above, not all steps were applicable to AHCCCS's evaluation of the Contractors' performance because AHCCCS:

- Selected the study topics, questions, indicators, and populations.
- Defined sampling methods, if applicable.
- Collected all or part of the data.
- Calculated Contractor performance rates.

Throughout the process, AHCCCS maintained confidentiality in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. The files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

AHCCCS provided the overall evaluation reports and plan-specific results to HSAG for its review and analysis for this 2006–2007 annual report.

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide aggregate performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented its recommendations to improve Contractor performance.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results across the Contractors. As noted above, two of AHCCCS's eight current ALTCS EPD Contractors (i.e., Bridgeway Health Solutions and SCAN Long Term Care) had not been AHCCCS Contractors long enough for AHCCCS to have data available for them.

Contractor-Specific Results

AHCCCS provided to HSAG its CYE 2007 Contractor PIP performance results for six ALTCS EPD Contractors and for DES/DDD. The six ALTCS EPD Contractors are: Cochise Health Systems (CHS), Evercare Select (ES), Mercy Care Plan (MCP), Pima Health Systems (PHS), Pinal/Gila Long Term Care (P/GLTC), and Yavapai County Long Term Care (YCLTC). The PIP conducted during CYE 2007 was Management of Comorbid Diseases and focused on reducing the effects of comorbid/coexisting diseases by improving disease management and coordination of care. During CYE 2007, the Management of Comorbid Diseases PIP was in the first remeasurement phase; the measurement period was from October 1, 2004, to September 30, 2005.[8-1] The reported measures for the Management of the Comorbid Diseases PIP included:

- Median number of inpatient days
- Median number of outpatient encounters
- Median number of emergency room (ER)/urgent care (UC) visits.

In addition to the reported measures, this PIP evaluated the extent to which members' outcomes worsened, remained the same, or became better over time. These outcomes were determined by changes in members' acuity status, placement, and mortality status. Based on Contractor evaluations, members' levels of acuity were assessed using the Uniform Assessment Tool (UAT), where Level I represents the lowest level of acuity or severity based on a scale of I to III. The individual Contractor results are presented next.

[8-1] This PIP was a longitudinal study in which data was compared over a three-year period. The initial baseline measurement period for this PIP was October 1, 2002, to September 30, 2003.

Cochise Health Systems

CHS serves eligible, enrolled members in Cochise, Graham, and Greenlee counties and has contracted with AHCCCS since 1993. At the time of this annual review, the Contractor had approximately 900 members.

Findings

Table 8-1 presents the baseline and first remeasurement results for this PIP as well as the results of statistical testing for changes in the reported rates.

Table 8-1—Performance Improvement Projects—Comorbid Disease *for* CHS

PIP Measure	Baseline Oct. 1, 2002, to Sept. 30, 2003	Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Median Number of Inpatient Days	0	1	p=.283
Median Number of ER/UC Visits	**0**	**1**	**p=.001**
Median Number of Outpatient Encounters	**47**	**122**	**p<.001**

Note: Eligible members in the sample frame reside in their home and have at least two of the specified diseases. Rates in bold indicate statistical significance.

Table 8-1 shows a statistically significant and substantively large increase in the median number of outpatient encounters between the two measurement periods (from 47 to 122, p<.001). The median number of ER/UC visits also significantly increased (from 0 to 1, p=.001) while the median number of inpatient days did not change significantly between baseline and remeasurement (p=.283). In the CYE 2006 review, HSAG noted that increases in the average number of outpatient encounters may lead to a decrease in the other two measures. This result did not occur. However, there may be a plausible lag between an increase in outpatient encounters and a decrease in inpatient days and ER/UC visits. If so, improvement in these measures might be seen during the next measurement cycle.

During the remeasurement period, members' outcomes—as determined by acuity status, placement, and mortality status—were reevaluated. Overall, outcomes worsened for 30.4 percent of the sample frame (moving from Level I or II to a higher level) while zero percent of the members exhibited improvement in their outcomes. However, the majority of members (69.6 percent, or 32 of 46 members) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

As part of its improvement activities to more effectively manage comorbid/coexisting disease and to overcome identified barriers, CHS implemented interventions in the following areas:

- **Cultural and Linguistic Barriers**: Implemented annual cultural sensitivity training for all case managers

- **Ongoing Education**: Provided member newsletters and case management, conducted chart audits and site reviews to make certain home health provider education was completed, conducted annual behavioral health training for case managers and service providers, and included education during Provider Council meetings
- **Provider Incentives/Rewards**: Implemented provider compliance rewards for excellent performance results
- **Noncompliance**: Enhanced case management for noncompliant members, conducted satisfaction surveys and medical/utilization management reviews, enhanced the peer review and quality-of-care concerns processes, and strengthened provider education through mailings, in-services, and/or face-to-face meetings
- **Care Coordination**: Actively sought to contract with additional PCPs, home health agencies, and other home health services and attempted to increase the number of other providers of care coordination who were AHCCCS-approved

Strengths

The large improvement in the median number of outpatient encounters provides evidence of the combined strength of the implemented interventions. While a decrease in the median number of inpatient days and ER/UC visits did not materialize during the first remeasurement of this PIP, improvement based on current interventions may be seen during the next remeasurement.

Opportunities for Improvement and Recommendations

The median number of ER/UC visits showed a statistically significant increase between the baseline and first remeasurement reporting periods. This finding suggests that a root-cause analysis should be performed by CHS. If the increase in ER/UC visits is shown to be predominantly during nonoffice hours, the Contractor should implement additional interventions to address member access to primary care services during these times. Additionally, while the increase in the median number of inpatient days was not statistically significant (p=.283), the Contractor should investigate the relative increase. Although this increase is not as statistically clear as the increase in ER/UC visits, early interventions might prevent future declines in performance on this PIP.

Summary

The interventions the Contractor implemented are chronologically associated with the large increase in the median number of outpatient encounters. The quality improvement activities also have face validity due to their logical association with the goals of the project. Based on the first remeasurement results, further efforts are recommended to reduce the median number of ER/UC visits and, potentially, the median number of inpatient days.

Evercare Select

ES serves eligible, enrolled members in Maricopa, Mohave, Coconino, Apache, and Navajo counties and has contracted with AHCCCS since October 1, 1989. At the time of this annual review, the Contractor had approximately 5,100 members.

Findings

Table 8-2 presents the baseline and first remeasurement results for this PIP as well as the results of statistical testing for changes in the reported rates.

Table 8-2—Performance Improvement Projects —Comorbid Disease *for* ES

PIP Measure	Baseline Oct. 1, 2002, to Sept. 30, 2003	Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Median Number of Inpatient Days	0	0	p=.464
Median Number of ER/UC Visits	**0**	**0**	**p=.002**
Median Number of Outpatient Encounters	**29**	**69**	**p=.022**

Note: Eligible members in the sample frame reside in their home and have at least two of the specified diseases. Rates in bold indicate statistical significance.

Table 8-2 shows a statistically significant and substantively large increase in the median number of outpatient encounters between the two measurement periods (from 29 to 69, p=.022). The median number of ER/UC visits also significantly increased (from 0 to 0, p=.002), while the median number of inpatient days did not change significantly between baseline and remeasurement (p=.464).[8-2] In the CYE 2006 review, HSAG noted that increases in the average number of outpatient encounters may lead to a decrease in the other two measures. Unfortunately, this result did not occur. However, there may be a plausible lag between an increase in outpatient encounters and a decrease for inpatient days and ER/UC visits. If so, improvement in these measures might be seen during the next measurement period.

During the remeasurement period, members' outcomes—as determined by acuity status, placement, and mortality status—were also reevaluated. Overall, outcomes worsened for 25.3 percent of the sample frame (moving from Level I or II to a higher level) while 10.8 percent of the members exhibited improvement in their outcomes. However, the majority of members (63.9 percent, or 53 of 83 members) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

[8-2] The direction of significant changes in identical median scores was assessed based on additional data provided by AHCCCS.

As part of its improvement activities to more effectively manage comorbid/coexisting disease and to overcome identified barriers, ES implemented interventions in the following areas:

- **Care Coordination**: Increased efforts by case managers to follow up with members following an inpatient discharge or ER visit and implemented ongoing review of cases by case managers and the medical director
- **Disease Management**: Implemented a telemonitoring pilot for members with a high volume of inpatient and ER encounters and implemented a health plan survey completed by PCPs to ensure that members with diabetes receive care under best practice guidelines
- **Cultural and Linguistic Barriers**: Conducted cultural competency training for case managers and actively assigned Spanish-speaking members to Spanish-speaking case managers

Strengths

The large improvement in the median number of outpatient encounters provides evidence of the combined strength of the implemented interventions. While a decrease in the median number of inpatient days and ER/UC visits did not materialize during the first remeasurement of this PIP, improvement based on current interventions may be seen during the next remeasurement.

Opportunities for Improvement and Recommendations

While the median number of outpatient encounters significantly increased between the baseline and remeasurement periods, the median number of inpatient days did not show significant improvement (p=.464). As such, an opportunity for improvement continues to exist for ES. The Contractor should conduct a root-cause analysis to identify the factors responsible for improving outpatient utilization as well as those affecting the utilization of inpatient days. Depending on the outcome of this analysis, interventions can be adjusted to address identified areas of concern. However, there may be a plausible lag between an increase in the median number of outpatient encounters and a subsequent decline in the median number of inpatient days. Therefore, the continued strengthening of interventions and improvements in outpatient utilization may lead to improvements in the other measures during the next measurement period. The statistically significant increase in the median number of ER/UC visits also represented an opportunity for improvement, and should be evaluated for additional interventions.

Summary

The interventions the Contractor implemented are chronologically associated with the large increase in the median number of outpatient encounters. The quality improvement activities also have face validity due to their logical association with the goals of the project. Based on the first remeasurement results, additional efforts should be undertaken to reduce the median number of inpatient days and ER/UC visits.

Mercy Care Plan

MCP serves eligible ALTCS members in the Maricopa GSA and has been an AHCCCS ALTCS EPD Contractor since 2000. At the time of this annual review, the Contractor had approximately 8,200 ALTCS members.

Findings

Table 8-3 presents the baseline and first remeasurement results for this PIP as well as the results of statistical testing for changes in the reported rates.

Table 8-3—Performance Improvement Projects—Comorbid Disease *for* MCP

PIP Measure	Baseline Oct. 1, 2002, to Sept. 30, 2003	Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Median Number of Inpatient Days	0	0	p=.832
Median Number of ER/UC Visits	**0**	**0**	**p<.001**
Median Number of Outpatient Encounters	**35**	**84**	**p<.001**

Note: Eligible members in the sample frame reside in their home and have at least two of the specified diseases. Rates in bold indicate statistical significance.

Table 8-3 shows a statistically significant and substantively large increase in the median number of outpatient encounters between the two measurement periods (from 35 to 84, p<.001). The median number of ER/UC visits also significantly increased (from 0 to 0, p<.001), while the median number of inpatient days did not change significantly between baseline and remeasurement (p=.832).[8-3] In the CYE 2006 review, HSAG noted that increases in the average number of outpatient encounters may lead to a decrease in the other two measures. Unfortunately, this result did not occur. However, there may be a plausible lag between an increase in outpatient encounters and a decrease in inpatient days and ER/UC visits. If so, improvement in these measures might be seen during the next measurement period.

During the remeasurement period, members' outcomes—as determined by acuity status, placement, and mortality status—were also reevaluated. Overall, outcomes worsened for 30.3 percent of the sample frame (moving from Level I or II to a higher level) while 4.5 percent of the members exhibited improvement in their outcomes. However, the majority of members (65.2 percent, or 58 of 89 members) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

As part of its improvement activities to more effectively manage comorbid/coexisting disease and to overcome identified barriers, MCP implemented interventions in the following areas:

[8-3] The direction of significant changes in identical median scores was assessed based on additional data provided by AHCCCS.

- **Assessment:** Trained case managers on a predictive modeling tool to help identify members at greatest risk and had the medical director evaluate each study member to determine whether he or she required services by MCP's Medically Complex Care Team
- **Care Coordination**: Enhanced communication with and from providers; augmented case management visits, as necessary, to improve care coordination; and assigned nurse case managers to high-risk members identified in the PIP
- **Disease Management**: Enhanced member education efforts aimed at improving self-management; implemented a new tracking system to capture member needs, diseases, and interactions; and conducted case manager and nurse-case manager education sessions to increase knowledge of common conditions and disease processes

Strengths

The large improvement in the median number of outpatient encounters provides evidence of the combined strength of the implemented interventions. While a decrease in the median number of inpatient days did not materialize during the first remeasurement of this PIP, improvement based on current interventions may be seen during the next remeasurement.

Opportunities for Improvement and Recommendations

While the median number of outpatient encounters significantly increased between the baseline and remeasurement periods, the median number of inpatient days did not show significant improvement (p=.832). As such, an opportunity for improvement continues to exist for MCP. The Contractor should conduct a root-cause analysis to identify the factors responsible for improving outpatient utilization as well as those affecting the utilization of inpatient days. Depending on the outcome of this analysis, interventions should be adjusted to address identified areas of concern. However, there may be a plausible lag between an increase in the median number of outpatient encounters and a subsequent decline in the median number of inpatient days. Therefore, the continued strengthening of interventions and improvements in outpatient utilization may lead to improvements in the other measures during the next measurement period. The statistically significant increase in the median number of ER/UC visits was also identified as an opportunity for improvement, and should be evaluated for additional interventions.

Summary

The interventions the Contractor implemented are chronologically associated with the large increase in the median number of outpatient encounters. The quality improvement activities also have face validity due to their logical association with the goals of the project. Based on the first remeasurement results, additional efforts should be undertaken to reduce the median number of inpatient days. MCP's results for the median number of ER/UC visits increased and were statistically significant (p<.001).

Pima Health Systems

PHS serves eligible enrolled members in Pima and Santa Cruz counties. PHS has contracted with AHCCCS since October 1, 1988. At the time of the annual review, the Contractor had approximately 3,900 members.

Findings

Table 8-4 presents the baseline and first remeasurement results for this PIP as well as the results of statistical testing for changes in the reported rates.

Table 8-4—Performance Improvement Projects—Comorbid Disease *for* PHS

PIP Measure	Baseline Oct. 1, 2002, to Sept. 30, 2003	Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Median Number of Inpatient Days	1	0	p=.778
Median Number of ER/UC Visits	**0**	**0**	**p=.001**
Median Number of Outpatient Encounters	**27**	**61**	**p<.001**

Note: Eligible members in the sample frame reside in their home and have at least two of the specified diseases. Rates in bold indicate statistical significance.

Table 8-4 shows a statistically significant and substantively large increase in the median number of outpatient encounters between the two measurement periods (27 to 61, p<.001). The median number of ER/UC visits also significantly increased (from 0 to 0, p=.001) while the median number of inpatient days did not change significantly between baseline and remeasurement (p=.778).[8-4] In the CYE 2006 review, HSAG noted that increases in the average number of outpatient encounters may lead to a decrease in the other two measures. Unfortunately, this result did not occur. However, there may be a plausible lag between an increase in outpatient encounters and a decrease for inpatient days and ER/UC visits. If so, improvement in these measures might be seen during the next measurement period.

During the remeasurement period, members' outcomes—as determined by acuity status, placement, and mortality status—were also reevaluated. Overall, outcomes worsened for 30.2 percent of the sample frame (moving from Level I or II to a higher level) while 3.5 percent of the members exhibited improvement in their outcomes. However, the majority of members (66.3 percent, or 57 of 86 members) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

As part of its improvement activities to more effectively manage comorbid/coexisting disease and overcome identified barriers, PHS implemented interventions in the following areas:

[8-4] The direction of significant changes in identical median scores was assessed based on additional data provided by AHCCCS.

- **Assessment**: Collected and reviewed data from case managers regarding members' ER/UC and inpatient utilization as well as whether the member tried to contact his or her PCP prior to visiting the ER. PHS also implemented an education program for members who failed to contact their PCP prior to visiting the ER.
- **Disease Management**: Enhanced member newsletters by including articles that provided information on how to reduce ER/UC visits as well as disease-specific information on diabetes and asthma.
- **Care Coordination**: Expanded the role of PHS's Behavioral Health Team in providing necessary behavioral health services to members.

Strengths

The large improvement in the median number of outpatient encounters provides evidence of the combined strength of the implemented interventions. While a decrease in the median number of inpatient days did not materialize during the first remeasurement of this PIP, improvement based on current interventions may be seen during the next remeasurement.

Opportunities for Improvement and Recommendations

Notwithstanding the fact that the median number of outpatient encounters significantly increased between the baseline and remeasurement periods, the median number of inpatient days did not show significant improvement (p=.778). As such, an opportunity for improvement continues to exist for PHS. The Contractor should conduct a root-cause analysis to identify the factors responsible for improving outpatient utilization as well as those affecting the utilization of inpatient days. Depending on the outcome of this analysis, interventions should be adjusted to address identified areas of concern. However, there may be a plausible lag between the increase in the median number of outpatient encounters and a subsequent decline in the median number of inpatient days. Therefore, the continued strengthening of interventions and improvements in outpatient utilization may lead to improvements in the other measures during the next measurement period. The statistically significant increase in the median number of ER/UC visits also represented an opportunity for improvement, and should be evaluated for additional interventions.

Summary

The interventions the Contractor implemented are chronologically associated with the large increase in the median number of outpatient encounters. The quality improvement activities also have face validity due to their logical association with the goals of the project. Based on the first remeasurement results, additional efforts should be undertaken to reduce the median number of inpatient days. The increase in PHS's results for the median number of ER/UC visits were also statistically significant (p<.001.

Pinal/Gila Long Term Care

P/GLTC serves eligible, enrolled members in Pinal and Gila counties and has contracted with AHCCCS since October 1, 1990. At the time of this review, the Contractor had approximately 1,250 members.

Findings

Table 8-5 presents the baseline and first remeasurement results for this PIP as well as the results of statistical testing for changes in the reported rates.

Table 8-5—Performance Improvement Projects—Comorbid Disease *for* P/GLTC

PIP Measure	Baseline Oct. 1, 2002, to Sept. 30, 2003	Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Median Number of Inpatient Days	**2.5**	**0**	**p=.006**
Median Number of ER/UC Visits	0	0	p=.056
Median Number of Outpatient Encounters	56	76.5	p=.209

Note: Eligible members in the sample frame reside in their home and have at least two of the specified diseases. Rates in bold indicate statistical significance.

Table 8-5 shows the median number of inpatient days decreased significantly between the baseline and remeasurement periods (from 2.5 to 0, p=.006). This finding indicates considerable improvement in P/GLTC's management of comorbid/coexisting disease. Additionally, while the change in the median number of outpatient encounters was not statistically significant (p=.209), the relative increase from 56 (baseline) to 76.5 (remeasurement) suggests improvement. The median number of ER/UC visits somewhat increased, and approached statistical significance (p=.056).[8-5]

During the remeasurement period, members' outcomes—as determined by acuity status, placement, and mortality status—were also reevaluated. Overall, outcomes worsened for 34.7 percent of the sample frame (moving from Level I or II to a higher level) while 6.1 percent of the members exhibited improvement in their outcomes. However, the majority of members (59.2 percent, or 29 of 49 members) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

As part of its improvement activities to more effectively manage comorbid/coexisting disease and to overcome identified barriers, P/GLTC implemented interventions in the following areas:

- **Care Coordination**: Implemented multidisciplinary care teams for members with special health care needs

[8-5] The direction of significant changes in identical median scores was assessed based on additional data provided by AHCCCS.

- **Assessment**: Enhanced monitoring of emergency room utilization and identified frequently occurring inpatient diagnoses to support the development of targeted interventions that improve member outcomes and reduce acute care costs

Strengths

The statistically significant decrease in the median number of inpatient days coupled with the relative increase in the median number of outpatient encounters suggests that the interventions the Contractor implemented are improving the quality of care for this population. These findings represent an overall strength for P/GLTC.

Opportunities for Improvement and Recommendations

P/GLTC was the only ALTCS EPD Contractor whose median number of outpatient encounters did not significantly increase, despite the fact that:

- There was a statistically significant decrease in the median number of inpatient days.
- The quality improvement activities the Contractor implemented were chronologically associated with the decrease in inpatient days and have face validity due to their logical association with the goals of the project.

P/GLTC may want to identify additional improvement opportunities to further increase member outpatient visits and/or decrease ER/UC visits. Specifically, the Contractor should:

- Investigate whether issues of access and convenience (e.g., appointment availability, office hours, provider panel status, transportation, etc.) are preventing members from accessing outpatient services.
- Strengthen member education materials about the appropriate use of emergency and urgent care services.
- Explore the reasons members continue to use ER/UC services when clinically, outpatient services would be appropriate.

Once the barriers are identified, the Contractor can then identify associated, targeted interventions.

Summary

P/GLTC experienced the greatest degree of improvement in the median number of inpatient days among the ALTCS EPD Contractors as well as the smallest gain in the median number of outpatient encounters.[8-6] These results suggest that additional quality improvement activities should be considered that will increase member use of outpatient services and decrease the inappropriate use of ER/UC services.

[8-6] The difference between the values at remeasurement and baseline (76.5-56=20.5) represented the smallest difference found among the ALTCS EPD Contractors.

Yavapai County Long Term Care

YCLTC serves eligible, enrolled members in Yavapai County and has contracted with AHCCCS since October 1, 1993. At the time of this annual review, the Contractor had approximately 930 members.

Findings

Table 8-6 presents the baseline and first remeasurement results for this PIP as well as the results of statistical testing for changes in the reported rates.

Table 8-6—Performance Improvement Projects—Comorbid Disease *for* YCLTC

PIP Measure	Baseline Oct. 1, 2002, to Sept. 30, 2003	Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Median Number of Inpatient Days	0	0	p=.722
Median Number of ER/UC Visits	**0**	**1**	**p=.003**
Median Number of Outpatient Encounters	**67**	**116**	**p<.001**

Note: Eligible members in the sample frame reside in their home and have at least two of the specified diseases. Rates in bold indicate statistical significance.

Table 8-6 shows statistically significant and substantively large increases for both the median number of outpatient encounters (from 67 to 116, p<.001) and ER/UC visits (from 0 to 1, p=.003). Compared to other ALTCS EPD Contractors whose median number of ER/UC visits remained at zero but showed a statistically significant change, YCLTC's indicators appear to have increased by a comparatively large amount. The increase was evidenced by a change that was statistically significant and a value that changed from zero to one. Additionally, no statistically significant change was documented in the median number of inpatient days (p=.772) and the value remained at zero.

In the CYE 2006 review, HSAG noted that increases in the average number of outpatient encounters may lead to a decrease in the other two measures. This anticipated decrease did not occur. However, there may be a plausible lag between an increase in outpatient encounters and a decrease for inpatient days and ER/UC visits. If so, improvement in these measures might be seen during the next measurement period.

During the remeasurement period, members' outcomes—as determined by acuity status, placement, and mortality status—were also reevaluated. Overall, outcomes worsened for 30.2 percent of the sample frame (moving from Level I or II to a higher level) while none of the members exhibited improvement in their outcomes. However, the majority of members (69.8 percent, or 30 of 43 members) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

As part of its improvement activities to more effectively manage comorbid/coexisting disease and overcome identified barriers, YCLTC implemented interventions in the following targeted areas:

- **Care Coordination**: Improved organizational structure by hiring a clinical case coordinator to manage the complex medical needs of members with coexisting diseases and published a quarterly provider newsletter that addressed key topics, including nutrition, patient safety, behavioral health, and management of diseases.
- **Assessment**: Implemented quarterly screenings for members to identify behavioral health needs as well as to facilitate referrals as necessary. YCLTC also identified members with chronic conditions (i.e., congestive heart failure, chronic obstructive pulmonary disease, and diabetes) and provided them or their caregivers with disease-specific information about self-management guidelines, signs and symptoms of worsening disease, and indicators that highlight the need for medical interventions.
- **Education**: Initiated training for assisted living facility staff on injury prevention.

Strengths

The large improvement in the median number of outpatient encounters provides evidence of the combined strength of the implemented interventions. However, this finding is tempered by the large increase in the median number of ER/UC visits and the lack of change in the median number of inpatient days. While a decrease in the median number of inpatient days or ER/UC visits did not materialize during the first remeasurement of this PIP, improvement based on current interventions may be seen during the next remeasurement.

Opportunities for Improvement and Recommendations

The statistically significant increase in the median number of ER/UC visits identifies this measure as the greatest opportunity for improvement for YCLTC. Although the reported increase from zero to one could understandably be overinterpreted, only one other ALTCS EPD Contractor had a value of one for this indicator during remeasurement. This finding suggests that the median number of ER/UC visits is a relatively important opportunity for improvement from a Contractor-wide perspective. The Contractor should convene a multidisciplinary team to conduct a root-cause analysis of the factors contributing to the increase in ER/UC utilization. If additional barriers are identified that prevent members from accessing outpatient services, targeted interventions should be implemented to redirect members to more appropriate services. Additionally, further improvement in median number of outpatient encounters should eventually be seen to lead to an improvement in the median number of inpatient days and ER/UC encounters.

Summary

The statistically significant increase in the median number of outpatient encounters was a strength for the Contractor while the median number of ER/UC visits highlights an opportunity for improvement. Coupled with the lack of significant change in the median number of inpatient days, these results present mixed success for YCLTC in working toward achieving the goals of this PIP.

Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

DES/DDD serves eligible, enrolled members in all 15 counties in Arizona and has contracted with AHCCCS since 1989. At the time of this annual review, the Contractor had approximately 19,200 members.

Findings

For CYE 2007, DES/DDD completed the second remeasurement of its Immunization Completion Rate PIP. Table 8-7 presents the first and second remeasurement cycle results for this PIP as well as the results of statistical testing for the change in the presented completion rates.

Table 8-7—Performance Improvement Projects
Immunization Completion Rates by 24 Months of Age *for* DES/DDD

PIP Measure	1st Remeasurement Oct. 1, 2003, to Sept. 30, 2004	2nd Remeasurement Oct. 1, 2004, to Sept. 30, 2005	Statistical Significance (*p* value)
Immunization Completion Rates by 24 Months of Age	**45.2%**	**65.2%**	**p=.003**

Note: Rates in bold indicate statistical significance.

Table 8-7 shows the immunization completion rate by 24 months of age increased 20.0 percentage points between the first remeasurement (45.2 percent) and second remeasurement (65.2 percent). The reported increase represented a 44.2 percent change and was statistically significant. This finding suggests that current interventions are effectively increasing the percentage of children receiving immunizations by 24 months of age.

As part of its improvement activities to increase the number of children receiving immunizations and to overcome identified barriers, DES/DDD implemented interventions in the following areas:

- **Provider Trends**: Continued ongoing monitoring and analysis of immunization trends among contracted health plans to generate interventions with identified providers.
- **Reminder/Call Systems**: Demonstrated the features and use, as well as the monitoring of use, of DES/DDD's reminder/call system for both providers and families. DES/DDD also implemented incentives for compliance with DES/DDD's reminder/call system.
- **Education**: Enhanced ongoing mailings and informational bulletins sent to families stressing the importance of immunizations, and initiated core training for new support coordinators stressing the importance of childhood immunization.
- **Data Collection Methodology**: Generated informational reports on providers' efforts to report vaccinations and obtain third-party reimbursement for eligible members.
- **Identified Barrier Resolutions**: Implemented strategies to obtain and provide necessary documentation for immunizations, and continued to work on resolving transportation problems.

Strengths

The outcome of the current review indicated a large, statistically significant improvement in the percentage of children 24 months of age who received a complete set of immunizations. These findings indicate that this PIP activity was a strength for DES/DDD.

Opportunities for Improvement and Recommendations

Given the positive outcome presented in the current review cycle, it is recommended that DES/DDD continue current interventions to further increase its rate.

Summary

The large and significant gain for the Immunization Completion Rates by 24 Months of Age PIP is a recognized achievement for DES/DDD.

Comparative Results for ALTCS EPD Contractors

The median numbers of inpatient days and ER/UC visits are constructed such that they will typically return integer values. Compared to the size of the measures' denominators, the numerators are quite small and typically result in values that are often zero or one. Nonetheless, the large denominators create statistical power that allows for a statistically significant change without the returned value changing.

Findings

The most consistent finding for the PIPs in the first remeasurement period was the overall increase in the median number of outpatient encounters. Figure 8-1 presents the results for this measure for the six ALTCS EPD Contractors.

Figure 8-1—2-Year Comparison of Median Number of Outpatient Encounters *for* ALTCS EPD Contractors[8-7]

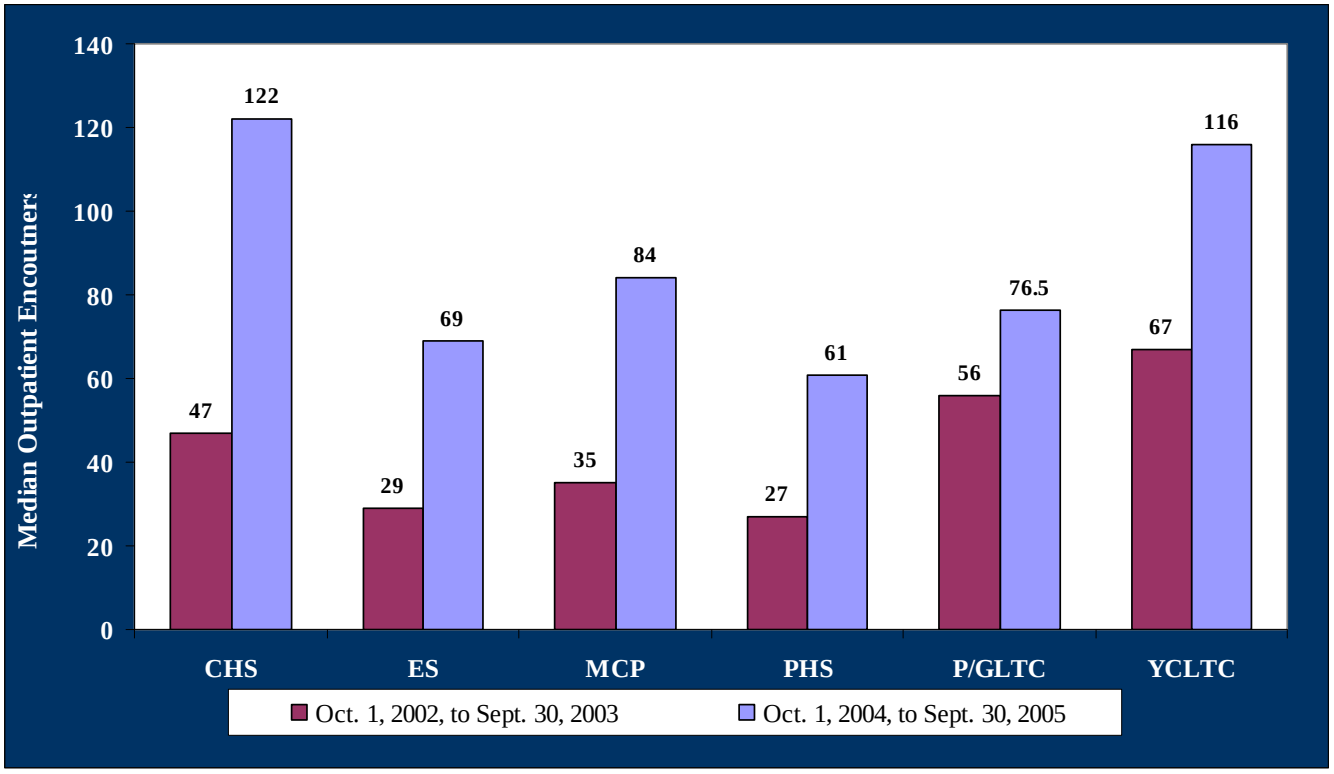


Figure 8-1 shows that the median number of outpatient encounters increased for each EPD Contractor. Moreover, the overall rate of outpatient encounters exhibited a statistically significant increase from baseline rates ($p<.001$). When stratified by ALTCS EPD Contractors, the results showed that only P/GLTC's rate remained statistically unchanged from the baseline period. All

[8-7] The Contractor names were abbreviated as follows: CHS=Cochise Health Systems, ES=Evercare Select, MCP=Mercy Care Plan, PHS=Pima Health Systems, P/GLTC=Pinal/Gila Long Term Care, and YCLTC=Yavapai County Long Term Care.

remaining Contractors showed statistically significant and substantively large increases between the two measurement periods. This finding suggests improved coordination of care and access to preventive services for these members.

The values for median number of inpatient days and ER/UC encounters were generally zero or one. Although graphics and tables with multi-decimal averages do not yield as much interpretable information as measures such as a mean, some statistics can be performed for the median, as AHCCCS calculated and HSAG has reported in this report. Although not shown in the figure, the only statistically significant change in the median number of inpatient days was for P/GLTC, which had its median decrease significantly from 2.5 to 0 days (p=.006). This result suggests successful execution of the PIP by P/GLTC. The results for the median number of ER/UC visits significantly increased for all EPD Contractors except P/GLTC. Moreover, as noted in AHCCCS's report, the median number of ER/UC visits significantly increased for all ALTCS EPD Contractors (p<.001).

As separately described for each ALTCS EPD Contractor, members' outcomes were reevaluated during remeasurement. Overall, outcomes worsened for 29.8 percent of the sample frame (moving from Level I or II to a higher level). This average percentage ranged from 25.3 percent to 34.7 percent across Contractors. Overall, the outcomes became better for 4.8 percent of the participating members. The majority of members (65.4 percent, or 259 of 396 members across all Contractors) had outcomes that remained the same between measurement periods. When interpreting the results, it is important to note that outcomes would be expected to worsen over time without clinical management. Therefore, the longer-term effectiveness of the interventions is expected to somewhat reduce the number of members whose outcomes worsen between measurement cycles as the PIP continues.

Strengths

Figure 8-1 demonstrates the relative success of each EPD Contractor in increasing the median number of outpatient encounters for eligible members with comorbid diseases. Except for P/GLTC, every EPD Contractor increased its results for this measure by a statistically significant amount. In addition, the statistically significant increases were substantively large. The increasing values shown by P/GLTC, while not statistically significant (p=.209), were suggestive of improvement. Additionally, the significant decrease in P/GLTC's median number of inpatient days was a recognized strength and success for its PIP.

Opportunities for Improvement and Recommendations

Two of the three quality indicators for the current PIP have not yet shown clear evidence of Contractor-wide improvement (i.e., median numbers of inpatient hospital days and ER/UC visits). The reasons for these opportunities for improvement were not clear from the available documentation and may not be known to the Contractors. HSAG encourages the Contractors to perform a root-cause analysis whenever the returned results are not as predicted based on the quality improvement interventions already operationalized. Based on the results of the analysis, Contractors may need to strengthen current interventions and/or implement additional ones.

Summary

The six ALTCS EPD Contractors returned mixed results for the Management of Comorbid Diseases PIP. Although the median number of outpatient encounters increased by statistically significant and substantively important amounts between measurement periods, performance for the other measures did not similarly improve.